INCREASING PROVIDER PARTICIPATION

NATIONAL GOVERNORS' ASSOCIATION

STATE POLICY REPORTS

HEALTH STUDIES

STRATEGIES FOR IMPROVING STATE PERINATAL PROGRAMS

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EXECUTIVE SUMMARY AND READER'S GUIDE

Assuring adequate provider participation has been a perennial concern for Medicaid, Maternal and Child Health, and other public programs for low-income pregnant women and children. Over the years, low provider fees and programmatic complexity have been the principal explanations offered for poor provider participation rates. Today, new factors – especially the rising cost of malpractice insurance – are cited as major causes of declining participation among providers of prenatal and delivery services.

The growing sense of a "crisis" in obstetrical care comes at a particularly inopportune time for the states. The Omnibus Budget Reconciliation Acts of 1986 and 1987 (OBRA-86 and OBRA-87) offer states new opportunities to expand Medicaid coverage for low-income pregnant women and thereby improve services through both Medicaid and Maternal and Child Health (MCH) programs. As of April 1988, thirty-three states had adopted, and twenty-two had already begun implementing poverty-level coverage. However, the ability of state agencies to take advantage of these new opportunities – and to maximize use of new resources – will depend, in part, on finding new and more effective ways to address the participation issue. A critical question has emerged regarding the potential success of program expansions: what purpose will be served when states extend coverage to thousands of newly eligible pregnant women if those women are unable to find enough providers willing to serve them?

In late 1987, the National Governors' Association requested a survey of state Medicaid and Maternal and Child Health agencies to (1) assess the extent of concern with the issue among state programs; (2) identify experiences and perceptions regarding the factors which inhibit provider participation; and (3) identify approaches different state agencies are using to address these problems. This report summarizes the results of that survey as well as the available literature regarding the issue of concern to states: how to assure that low-income women eligible for Medicaid and Maternal and Child Health services have access to providers of the care they require.

THE PROBLEM OF PROVIDER PARTICIPATION

Traditionally, a minority of physicians have provided the bulk of services to low-income patients. Medicaid participation among obstetricians and gynecologists (OB-GYNs) has been low, compared with that of other physicians. In 1976, 63.2 percent of OB-GYNs participated in Medicaid, compared with 77.4 percent of all physicians. OB-GYNs also had low average caseloads; only 8.3 percent of patients were Medicaid compared with 12.7 percent for all physicians and 13.3 percent for other primary care physicians.

The situation has not changed significantly since the 1970s. Today, it is estimated that no more than 60 percent of OB-GYNs provide services to Medicaid patients. Recent changes in obstetrical practice are likely to affect public programs further. According to the American College of Obstetrics and

Gynecology (ACOG) 1987 survey of its membership, 12.4 percent of OB-GYNs reported they have ceased obstetrical practice because of concern about malpractice suits – about the same proportion as in 1985 and higher than in 1983. About 27 percent have reduced high-risk obstetrical care and 12.9 percent have reduced their overall number of deliveries. In 1986, the American Academy of Family Physicians reported that 23.3 percent of members had stopped doing obstetrics due to malpractice concerns.

According to state agencies, these general reductions in obstetrical practice are having a particularly severe effect on the availability of care for low-income women. About three-quarters of respondents to the NGA survey, including 89 percent of Maternal and Child Health programs and 63 percent of Medicaid programs, said they are experiencing significant problems in provider participation for maternity care. In addition:

- Low participation is particularly acute in rural areas; thirty-five of the fifty states reported problems in rural areas; only three said they had problems in suburban/urban locales.
- In at least 484 counties in twenty-one states, low-income women receiving care through Medicaid or MCH programs have limited access to prenatal and delivery services. In all likelihood, this underestimates the problem, since these data were volunteered in response to an open-ended question.
- Fourteen states reported a total of 246 counties with no obstetrical care provider (general practitioner, family practitioner, or OB-GYN) at all. Three states reported closure of forty-two hospital obstetrical units in the last two years.

Why Providers Do Not Participate in Public Programs

The NGA survey asked state agencies to rank both the reasons they believed were the most important causes of low provider participation and the reasons given by physicians. Fee levels and malpractice costs were, by far, the most significant factors cited in both cases.

- Forty-six percent of all agencies considered low reimbursement to be the primary deterrent to participation. Medicaid agencies particularly attributed low participation to reimbursement.
- About 20 percent of the respondents considered malpractice costs the most important reason for nonparticipation. MCH agencies were more likely to rank malpractice high on the list of problems – 25 percent listing it first, compared with 18 percent for Medicaid programs.
- While physicians also cite low reimbursement as the primary problem, they are more likely than are the state agencies to cite malpractice costs as the principal deterrent to participation. (Pages 1-9)

There has been significant research on the issue of physician participation, particularly in Medicaid programs. While these studies were conducted before malpractice became an identifiable concern, their findings are still important and relevant for state agencies.

Taken as a whole, a review of the literature on physician participation suggests the following:

1. Low participation among OB-GYNs is not a new phenomenon. While lower participation among OB-GYNs may have been tolerable in the past, new events – rising malpractice costs, withdrawal of family practitioners from obstetrics, and reductions in service by previously participating obstetricians – may be creating an intolerable crisis.

2. The differential between public and private payment levels appears to be more important than the absolute level of public program reimbursements in influencing the provider's economic decision on whether or not to participate. Studies have found that, while increases in Medicaid fees increase provider participation, equivalent increases in private fees reduce Medicaid participation by a greater margin. Since the literature indicates that equal percentage increases in private and public reimbursement levels can result in reduced participation, public program fees need to be increased at a greater rate in order simply to maintain, much less increase, provider participation.

3. The data indicate that fee increases have differential effects on participation. Reimbursement levels have significant influence on the dichotomous decision of whether or not to participate in Medicaid at all, but have a much smaller effect on the size of caseloads among participating practitioners. This suggests that raising fees across the board might be particularly appropriate in situations where participation rates, as an absolute, are low. Where the percentage of physicians participating is high, but average caseloads are low, fee increases may be a less effective tool for improving access.

4. The factors which influence physician participation appear to be changing. Studies done in 1978 and 1982 indicated that, while Medicaid policies are clearly important determinants, they are less important today than in years past. General market forces, outside the purview of state agencies, are having a more significant effect on physician participation, particularly among OB-GYNs. When malpractice was included as an explanatory variable in the mid-1970s, studies found no relationship between malpractice premium costs and participation. A similar study done today would probably arrive at different results. (Pages 11-17)

THE IMPACT OF MALPRACTICE ISSUES ON PHYSICIAN PARTICIPATION

The malpractice crisis of the past several years has added a new dimension to an already difficult situation. Obstetrician-gynecologists saw their premiums more than double between 1982 and 1985, compared to an 81 percent increase for all physicians. The most recent survey by ACOG reports that average premiums in 1986 were $30,507 – an increase of 46.5 percent since 1984. Premiums in 1987 rose to about $37,000 – another 21 percent increase.

All providers of maternity services are experiencing increases in malpractice insurance costs. Family practitioners doing obstetrics are paying premiums two and three times higher than their colleagues without obstetrical practice. A new insurance program for certified nurse-midwives has premiums of $3,500 in the first year, compared with $800 prior to 1985. Federal community health centers have seen their premiums rise from $800-$900 in 1985 to $12,000 in 1986.

With the rising cost and incidence of malpractice claims, it is not surprising that 93 percent of respondents to the NGA survey – including all of the MCH programs – reported that rising malpractice costs were affecting provider participation in their programs.

For the last ten years, the policy response to malpractice issues has largely focused on insurance and cost. Virtually every state has enacted some tort reforms including: (1) limiting awards, (2) establishing arbitration programs, (3) limiting attorney fees, (4) requiring periodic, rather than lump sum payments on awards, and (5) changing the statute of limitations for filing claims. Access to care may have been an underlying concern since, logically, if physicians cannot obtain reasonably priced malpractice coverage, they may cease to provide certain services and/or serve particular population groups. However, the implementation of tort reforms, which may reduce malpractice claims, seems to take considerable time to be reflected in reduced premium costs. Only six respondents (8 percent) to NGA's survey felt that malpractice reform in their state had improved participation in their program. It appears that tort reforms do not offer much assistance in improving provider participation, at least not in the short run. (Pages 19-20)

Malpractice Concerns and Access to Obstetrical Care

There is no single comprehensive set of data currently available that documents a relationship between rising malpractice costs, declining provider participation in public programs, and access to care. Much of the available information derives from anecdotal reports and/or single state studies.

Because the NGA survey includes a response from every state, except the District of Columbia, it may provide the broadest picture of access problems, at least from the perspective of state agencies. As previously noted, thirty-five of the fifty states reported participation and/or access problems affecting their

programs and 93 percent said rising malpractice costs contributed to the problem.

- Three-fifths of the agencies report physicians ceasing to provide care to clients of public programs and almost 70 percent report reduced participation.
- Ninety-three percent of the agencies report that OB-GYNs are dropping obstetrical practice; 87 percent report similar events among family practitioners.
- Four-fifths of respondents report that OB-GYNs are not taking new patients and 67 percent report reduced care for high-risk patients.
- The problem may be most severe for the MCH programs. Four-fifths of the state MCH programs report both reductions in care to high-risk women and reduced physician participation, compared to about half of Medicaid agencies.

Declining availability of public obstetrical care providers has direct impact on access for low-income women. A number of states highlight the need for women to travel long distances to obtain prenatal care – and the fact that lack of transportation means that many women are not getting early prenatal care. Others emphasize the difficulties in caring for high-risk women when local providers are not available. Several states, particularly in the western and mountain regions, mention patients traveling over 100 miles for both prenatal care and delivery. (Pages 20-23)

Malpractice-Related Reasons for Nonparticipation

There are two primary explanations for physician nonparticipation due to malpractice issues.

RISING PREMIUM COSTS AND LOW PUBLIC PROGRAM REIMBURSEMENT. Eighty-four percent of responding agencies said that physicians "often" say that they do not participate because public program fees are insufficient to cover their malpractice costs.

Public programs generally have paid providers at rates below the prevailing community charge for private patients. Data from the NGA survey for thirty-six states indicate that in 1986, the median state Medicaid program paid providers about 44 percent of the approximate community charge for total obstetrical care. The highest proportion in any state was 76 percent of private charges; the lowest was 15 percent.

FEAR OF SUIT. Somewhat over half of the state agencies said that physicians often cite the higher risk of serving low-income patients as a reason for nonparticipation; slightly under one-third said that the physicians believe "the poor sue more."

Nobody likes to be sued or defend his or her professional ability in a court of law. Obviously, there is a relationship between costs and risk, since premiums for all practitioners rise with the general increase in malpractice claims and

awards. The evidence suggests that a desire to limit individual risk of suit is a separate and distinct factor motivating physicians to reduce participation.

The relationship between service to low-income and/or public program patients and the risk of malpractice suits is complex. Over one-fourth of OB-GYNs report reducing their high-risk caseloads. Since low-income pregnant women tend, as a group, to be at higher risk, providers may perceive reducing services to this population as a direct method of risk management.

Another factor is the belief that "the poor sue more." To some, this belief is counterintuitive because the legal literature shows that the poor experience significant difficulties accessing legal services generally. It is difficult to believe that this pattern would not apply in the malpractice arena as well.

The empirical data on malpractice issues are quite limited—and they neither prove nor disprove the conclusion. Two studies of closed claims from malpractice insurers indicate that the proportion of claims brought by Medicaid recipients is similar to, or lower than, the proportion of the relevant population receiving Medical Assistance. A national survey of OB-GYNs found no relationship between Medicaid participation and threatened or actual litigation by Medicaid recipients. On the other hand, a survey of physicians in one state and a recent ACOG survey of hospitals regarding 1982 malpractice claims come to the opposite conclusion—that the proportion of claims from Medicaid recipients is higher than their proportion of the population. Given the level of concern about this question, further research is required before definitive statements can be made. (Pages 23-29)

IMPROVING PROVIDER PARTICIPATION

States are attempting to address the changing issues and problems regarding provider participation in a variety of ways. These initiatives fall into several distinct categories. (Pages 31-32)

Enhancing Reimbursement

A majority of states have increased reimbursement rates over the past several years. Thirty states reported that 1986 reimbursement rates were higher than their 1984 rates.

- In 1986, the average Medicaid payment for routine delivery by an OB-GYN was $360, ranging from $795 in Maryland to $150 in New Hampshire.
- The nationwide average for total obstetrical care in the thirty-three states reporting this method of reimbursement was $550—ranging from $1,508 in Massachusetts to $214 in New Jersey.
- Twenty states report plans to raise fees in 1987-88. Among the eleven states that provided new fee schedules, rates for total obstetrical care are projected to increase 50 percent—from an average of $472 to $709.

- Because of the importance of the differential between public and private payments, Medicaid fees were compared to the reported"approximate community charge" for total obstetrical care. Based on data from forty-one states, the average nationwide charge for total obstetrical care is $1,436. The average Medicaid fee in 1986 was approximately 44 percent of the average nationwide community charge. In that year, the highest state payment rate covered 76 percent of the community charge while the lowest covered 14 percent. Projected 1987-88 fee increases for nine states will increase rates from an average of 38 percent of the community charge to 57 percent.

Some states believe that these major fee increases will improve participation, while others are less optimistic; these states believe the increases may only stabilize current participation.

There also appears to be a small but growing trend toward changing fee structures and allowing more "fragmented" billing procedures. Thirty-three states reported that in 1986 they had global billing (a method that reimburses providers a flat fee for total obstetrical care). Package rates for prenatal care, excluding delivery, are becoming more common, as are ways to allow physicians the option of shifting from global to fee-for-service billing if the patient is referred to another physician. Two states (Louisiana and South Carolina) recently discontinued global billing for the total obstetrical package in favor of fee-for-service billing.

Finally, differential fee schedules are another tool for increasing reimbursements while encouraging provision of particular services. A number of states are paying higher rates for the first visit to recognize the higher costs involved in initial diagnosis. Two states adopted differential rates, based on the risk status of the patient. Increasingly, states are beginning to pay higher rates to providers that participate in special enhanced prenatal care programs for pregnant women. (Pages 32-39)

Broad Program-Related Initiatives

Comprehensive program initiatives to address infant mortality are being implemented by many states, particularly in the context of adopting expansions under OBRA-86. These initiatives hold promise to make Medicaid and other perinatal programs more attractive to the private provider community. One important aspect of the new programs is increased coordination between Medicaid and MCH programs. In addition to obvious advantages of coordination in providing patient care, these efforts offer potential for better relating MCH-provided prenatal care with Medicaid payment for deliveries, thereby reducing physician concern about risk. Approaches that focus directly on provider participation include:

- Using Alternative Providers: Many of the states want to expand use of certified nurse-midwives (CNMs) and nurse practitioners in maternity care programs. More than half have already implemented

such endeavors, either as Medicaid reimbursement policies or in staffing MCH programs. Given that the absolute number of CNMs is relatively small and the scope of their practice may be limited by state licensing laws, the ultimate success of these efforts bears watching.

- Organized Provider Recruitment: One-fifth of the agencies report active physician recruitment programs, including the establishment of positive, ongoing relationships with medical societies, active state intervention in instances of crisis, and organized recruitment efforts in conjunction with initiation of new programs. All of these efforts are characterized by close and immediate attention to the concerns expressed by providers and attempts to make state efforts to resolve these problems highly visible to the physician community. Some states believe that targeting recruitment around new programs is more effective, because the new program does not always carry with it the aura of problems providers have previously experienced.
- Monitoring Provider Participation: Some states try to monitor changes in provider participation, either on an ongoing basis or with the use of surveys. While accurate methods for tracking such changes are difficult to develop, given the weaknesses of the available provider data, a few states have developed county-level data that can be used to identify geographic areas with particular problems. (Pages 39-44)

Limiting the Effect of Malpractice Costs

A limited number of states have attempted to address the access component of malpractice issues directly, an approach used almost exclusively by MCH programs that employ physician staff. There are also a few, very limited experiments by state agencies and some local jurisdictions in using public funds to assist providers with malpractice insurance costs. One state is using appropriated funds to develop a risk reduction program.

Two relatively new approaches have been adopted by state legislatures in the context of malpractice reform.

- Virginia was the first state to adopt "no-fault" liability coverage for newborn birth-related neurological injuries. The program takes a defined set of severe injuries out of the tort claims process and provides for payments to be made through a workers-compensation-type system. Florida became the second state to adopt the approach in its 1988 malpractice reform legislation.

  In addition to offering potential for reducing malpractice claims and premium rates, the Virginia statute includes a provision to specifically address access problems for low-income women. The law requires physicians participating in the "no-fault" program to agree to "participate in the development of a program to provide obstetrical

care to patients eligible for Medical Assistance Services and to patients who are indigent, and . . . to participate in its implementation."

- Missouri adopted, under the state's general liability fund, a program that covers malpractice claims against physicians contracting to render services for local health departments. The statute provides that the state Legal Expense Fund, which is financed by appropriated general revenues, will cover claims against physicians "providing public health services without compensation or with minimal compensation to patients for medical care caused by pregnancy, delivery and child care under contract or employment agreement with a city or county health department."

The effectiveness of these approaches will depend, ultimately, on their implementation. As approaches that link malpractice tort reforms with access concerns, they provide models for addressing these related concerns directly. (Pages 44-47)

CONCLUSIONS

Many of the problems identified in this report have no easy solutions. Today's climate of concern about malpractice costs and risks will require states to develop new approaches to improving participation among obstetrical care providers. It matters little whether physician concerns derive from perceptions and beliefs or from objectively documented fact. The sense of risk in caring for low-income and/or high-risk women can assume its own reality—and agencies will need to find ways to reduce this feeling in order to improve participation.

Fee levels will clearly continue to be an issue. It will be important to see whether, over time, fee increases attract more physicians to the programs. If malpractice issues have altered the nature of physician decisionmaking, so that reducing risk has become as important as payment levels, fee increases may be less effective than one would expect. The trend toward significant increases in reimbursement allows for a "real life" assessment of this strategy's effectiveness. State agencies could expend substantial financial resources in the effort to improve participation, but if fee levels per se have become less important in today's environment, those resources might be better used in other ways.

While it appears that physicians are reducing public program participation in response to rising malpractice premium costs, it is not at all clear that reducing malpractice premium costs will reverse this pattern. Programs and legislative actions that link malpractice cost reforms to access concerns may be more effective than attempts to reduce claims and premiums. Development and implementation of such programs may require that state Medicaid and MCH agencies become more actively involved in what has traditionally been an insurance issue.

In developing new programs to improve care for women and children, state agencies might try to identify and address precise aspects of physician concern

about risk. Assuming it is true that obstetrical providers are increasingly risk-averse, case management programs, continuous eligibility, and expanded benefits like nutrition counseling should be attractive to them. Most of the literature provided by states in response to the NGA survey stress these programs as efforts to improve health outcomes for women and children. Provider recruitment materials might stress their effectiveness as risk-management tools as well.

These and similar questions are likely candidates for future research and evaluations. Unfortunately, many state programs appear unable to wait for such research results. The participation problems they experience – and the potential effect on nationwide efforts to improve maternal and child health services – call for immediate attention. It is hoped that this report can provide state agencies with new ideas to help them resolve the problems they face. (Pages 49-50)

1

Defining the Problem

Assuring adequate provider participation has been a perennial concern for Medicaid, Maternal and Child Health, and other public programs for low-income pregnant women and children. Low provider fees and programmatic complexity have traditionally been the principal explanations offered for poor provider participation rates. Today, new factors – especially the rising cost of malpractice insurance – are cited as major causes of declining participation among providers of prenatal and delivery services. Many counties have no providers willing to deliver babies.

The growing sense of "crisis" in obstetrical care comes at a particularly inopportune time. Infant and neonatal mortality rates have shown little improvement in recent years, and the number of mothers who receive no prenatal care or who receive it late is alarmingly high. Compared with nineteen other industrialized countries, the United States has dropped from sixth to last place in its efforts to reduce infant mortality.

Enactment of the Omnibus Budget Reconciliation Act of 1986 (OBRA-86) offered states new opportunities to expand Medicaid coverage for low-income pregnant women and children and thereby improve services through both Medicaid and Maternal and Child Health (MCH) programs. Further expansion options are available under Reconciliation Act provisions adopted in December 1987 (OBRA-87).

States have responded to this flexibility at an encouragingly fast rate. By April 1988, thirty-three states had adopted expanded coverage up to or near the federal poverty level for these critical populations.[1] The ability of state agencies to take advantage of these new federal options – and maximize use of new resources – will depend, in part, on finding new or more effective ways to address the participation issue. A critical question has emerged regarding the potential success of program expansions: what purpose will be served when states extend coverage to thousands of newly eligible pregnant women if those women are unable to find enough providers willing to serve them?

Traditionally, a minority of physicians have provided the bulk of services to low-income patients. National data from a 1976 HCFA survey showed that about 5.5 percent of all providers served almost one-third of all Medicaid patients.[2] Slightly under one-fourth of all physicians did not participate in Medicaid at all; Medicaid patients constituted less than 10 percent of the practice of another one-fourth.

Accurate nationwide information on provider participation is limited. Little comprehensive data are available on total providers and/or changes in participation in MCH programs. More data are available for Medicaid programs, but the information probably overstates the effective rate of participation. An enrolled Medicaid provider is one who has a provider number; a participating provider is one who has at least one Medicaid claim. These measures give equal weight to the provider serving an occasional Medicaid patient and one with a large Medicaid practice. As a result, the proportion of physicians who ostensibly "participate" may be high, but, if most have very few Medicaid patients, the effective participation rate may be significantly lower. Other problems in calculating this number include providers with more than one Medicaid provider number and providers participating in more than one state program. (See Appendix 1.)

Despite these difficulties, the national data do suggest some apparent declines in provider participation in Medicaid. Twenty-six states provided HCFA with updated participating physician data for 1985 or 1986. Of these, twelve (46 percent) experienced reductions in the number of enrolled physicians per 1,000 recipients during the 1980s. As shown in Table 1, participants per 1,000 recipients fell in ten of the states (38 percent).

Overall participation rates tend to obscure specific problem areas, particularly the major changes occurring in obstetrical practice. While time frames are not specified, according to the American College of Obstetrics and Gynecology 1987 survey of its membership, 12.4 percent of OB-GYNs – about the same proportion as in 1985 – reported they have ceased obstetrical practice because of concern about malpractice suits. About 27 percent have reduced high-risk obstetrical care and 12.9 percent have reduced the overall number of deliveries.[3] In 1986, the American Academy of Family Physicians reported that 23.3 percent of members had stopped doing obstetrics due to malpractice concerns.[4]

THE NGA SURVEY ON PROVIDER PARTICIPATION

There is every reason to believe that these general reductions in obstetrical practice are having a particular effect on availability of care for low-income women. In late 1987, the National Governors' Association surveyed state Medicaid and Maternal and Child Health agencies to:

- assess the extent of concern with the issue among state programs;
- identify experiences and perceptions regarding the factors that inhibit provider participation; and
- identify approaches different agencies use to address these problems.

Of the 101 agencies surveyed, 81 (80 percent) responded to the questionnaire; a response was received from at least one agency in every state.

About three-quarters of the 81 respondents, including 89 percent of Maternal and Child Health programs and 63 percent of Medicaid programs, said they

Table 1
Percentage Change in the Number of Enrolled and Participating Physicians per 1,000 Medicaid Recipients in Selected States During the 1980s
(Ranked by Change in Participating Physicians per 1,000 Recipients)

State	*Participating Physicians*	*Enrolled Physicians*	*Years of File Update**
Nebraska	-73.58%	-59.81%	1980/1986
Arkansas	-62.41	-28.47	1982/1985
New Hampshire	-62.08	75.51	1984/1985
New Jersey	-45.95	-68.23	1983/1985
Utah	-36.,32	-3.75	1983/1985
Georgia	-27.28	-43.49	1984/1986
Louisiana	-24.53	0.71	1982/1986
Washington	-20.20	-13.82	1984/1985
North Dakota	-19.41	-11.36	1983/1985
Montana	-0.37	-8.68	1984/1985
Virginia	3.61	18.52	1982/1986
West Virginia	4.62	9.98	1983/1986
Nevada	7.57	-57.76	1983/1986
Rhode Island	8.44	8.44	1984/1986
Iowa	9.51	-0.10	1983/1986
Idaho	14.06	15.65	1980/1985
Oregon	15.70	110.37	1984/1986
Texas	18.17	-21.72	1984/1986
California	25.07	-24.08	1984/1986
Minnesota	34.29	4.51	1984/1986
Ohio	36.15	12.88	1984/1985
Florida	39.37	17.62	1984/1985
Hawaii	78.70	60.39	1983/1985
South Dakota	102.90	243.84	1983/1986
Alabama	112.04	90.90	1983/1985
Vermont	219.45	148.41	1984/1985

NOTE: *Dates show the time period for which the change in participation per 1,000 is reported. These are the years in which HCFA reports the state provided updated provider file information. Large percentage changes occurring over a short period of time may be artifacts of the data or other errors.

SOURCE: HCFA, Analysis of State Medicaid Program Characteristics, 1984. Unpublished HCFA data, 1986.

are experiencing significant problems in provider participation for maternity care. Most of those who said participation was not a significant problem reported some cause for concern. After eliminating duplicative responses from different state agencies, the survey shows thirty-five of the fifty states reporting participation problems in at least some localities. (See Table 2.)

Table 2
Agencies Reporting Significant Provider Participation Problems

	Maternal and Child Health		*Medicaid*		*All Agencies*	
Yes	33	89.2%	27	62.8%	60	75.0%
No	4	10.8	13	30.2	17	21.3
Unsure	0	0.0	3	7.0	3	3.8
TOTAL	37	100.0%	43	100.0%	80*	100.0%

NOTE: *One agency responding to the survey did not answer this question.

SOURCE: National Governors' Association Survey of Provider Participation, 1988.

Provider participation has always been a major issue for Medicaid programs. The extent of concern among MCH programs is, therefore, noteworthy. Review of written information provided by respondents suggests several explanations. First, MCH agencies may be more immediately aware of problems in obstetrics, because of their programmatic focus on one type of service. Because of the breadth of services they render, Medicaid agencies may have responded in a more general fashion. Second, a high proportion of Medicaid recipients are in urban areas where hospitals and clinics can substitute for private practitioners. For example, Pennsylvania Medicaid noted that they did not have a participation problem because "hospitals and clinics are available in urban areas to serve the patients." Many MCH programs provide (or contract for) services in both urban and rural areas – and there may be no substitute for the private provider in these jurisdictions.

Although the NGA survey did not request statistical data on the extent of nonparticipation, twenty-one states volunteered such information in response to an open-ended question. Most of the others provided specific examples of geographic areas where participation problems are acute. Analysis of these responses provides a more concrete picture of the types of participation problems facing public programs.

- Concerns about the effect of low participation are particularly acute in rural areas. Thirty-five of the fifty states reported problems in rural areas; only three said they had problems in suburban/urban locales. Sixty Medicaid and MCH agencies indicated geographic areas with significant access problems. Eighty-seven percent of these

reported that the problem was particularly acute in rural parts of the state. (See Table 3.)

Table 3
Agencies Identifying Specific Geographic Areas with Major Participation Problems

	Maternal and Child Health		*Medicaid*		*All Agencies*	
Rural	29	76.3%	23	53.5%	52	64.2%
Urban	4	10.5	4	9.3	8	9.9
No Mention	5	13.2	16	37.2	21	25.9
TOTAL	38	100.0%	43	100.0%	81	100.0%

NOTE: Data tabulated from responses to an open-ended question asking agencies to discuss the types of problems they experience.

SOURCE: National Governors' Association Survey of Provider Participation, 1988.

- Compilation of the statistical data provided shows that in at least 484 counties in twenty-one states, low-income women receiving care through Medicaid or MCH programs have limited access to prenatal and delivery services. For these purposes, limited access was defined as (1) no provider in the county, (2) one provider serving many counties, or (3) sufficient difficulty in obtaining physician back-up/support that public prenatal care programs threatened to close or actually closed down.
- Fourteen states reported a total of 246 counties with no obstetrical care provider at all (general practitioner, family practitioner or obstetrician-gynecologist). Three states reported closure of forty-two hospital obstetrical units in the last two years.

Because these data were volunteered in response to an open-ended question, they probably understate the lack of availability of maternity care providers for low-income women. For example, the American Medical Association (AMA) reports 126 counties in twenty-five states with no physician practicing any type of medicine.[5] Since fourteen states reported 246 counties with no obstetrical care providers, there appear to be a number of localities which have some physicians, but none providing maternity services.

WHY PROVIDERS DO NOT PARTICIPATE IN PUBLIC PROGRAMS

The state agencies were asked to rank the reasons *they believed* were the most important causes of low provider participation. By far, fee levels and malprac-

tice costs were perceived to be the most significant factors impacting participation. When one of these factors was cited as the most important problem by a state program official, frequently the other was given second rank. (See Table 4.)

- Forty-six percent of all agencies considered low reimbursement to be the primary deterrent to participation and another one-fourth considered fees the second most important problem.
- About one-fifth of the respondents considered malpractice costs the most important reason for nonparticipation and 31 percent ranked this factor number two.
- Medicaid agencies tended to see low fees as more important deterrents than did the Maternal and Child Health programs. Fifty-three percent of Medicaid agencies gave low fees the highest ranking, compared with 39 percent of MCH programs. On the other hand, MCH programs tended to regard malpractice as slightly more significant—25 percent listing it first compared to 18 percent for Medicaid programs.
- Administrative issues, problems with clients, or a negative perception of the public program were infrequently mentioned as a major deterrent to participation. As might be expected, given the differences between the programs, Medicaid agencies were more likely to report administrative problems, such as complex forms or payment procedures. Although the numbers are small, it is interesting that MCH programs mentioned perceptions of clients and/or the program as important concerns more frequently than did Medicaid.

The agencies were also asked to indicate the reasons most frequently given *by physicians* for nonparticipation. (See Table 5.) In conveying their concerns to state officials, physicians also consider malpractice costs and low fees to be primary deterrents to participation. Slightly under one-half of the agencies reported low fees as the principal reason given by physicians for nonparticipation; about 30 percent blamed malpractice costs. Comparison of these responses with the agencies' own views on this issue reveals some interesting differences.

- Physicians are more likely to cite malpractice costs as the principal deterrent to participation. The difference between physician and agency views is particularly striking for the MCH programs. While more than two-fifths of MCH programs said that physicians cite malpractice expense as the most important reason for nonparticipation, only one-fourth said that they regarded malpractice costs as the major deterrent.
- MCH programs mentioned costs of malpractice coverage as the principal reason given by physicians twice as often as Medicaid programs. Forty-one percent of MCH programs said this was the primary reason given by physicians, compared to 18 percent of Medicaid programs.

Table 4
State Agency Perception of the Principal Reasons for Low Provider Participation

Reasons for Nonparticipation	*Percent Giving Highest Rank*	*Percent Giving Rank #2*
Low Fees		
MCH	38.9%	30.6%
Medicaid	52.6	21.1
Total	45.9	25.7
Malpractice		
MCH	25.0	30.6
Medicaid	18.4	31.6
Total	21.6	31.1
Complex Forms		
MCH	2.8	8.3
Medicaid	15.8	10.5
Total	9.5	9.5
Client Problems		
MCH	8.3	22.2
Medicaid	5.3	7.9
Total	6.8	14.9
View of Program		
MCH	8.3	8.3
Medicaid	0.0	3.6
Total	5.4	4.1
Payment Delay		
MCH	2.8	11.1
Medicaid	0.0	13.2
Total	1.4%	11.2%

NOTE: N = 74 total agencies; 36 MCH and 38 Medicaid

SOURCE: National Governors' Association Survey of Provider Participation, 1988.

Table 5
State Agency Views of the Principal Reasons Given by Physicians for Nonparticipation

Reasons for Nonparticipation	*Percent Giving Highest Rank*	*Percent Giving Rank #2*
Low Fees		
MCH	38.2%	35.3%
Medicaid	55.3	15.8
Total	47.2	25.0
Malpractice		
MCH	41.2	29.4
Medicaid	18.4	31.6
Total	29.2	30.6
Complex Forms		
MCH	0.0	11.8
Medicaid	13.2	23.7
Total	6.9	18.1
Client Problems		
MCH	2.9	8.8
Medicaid	2.6	5.3
Total	2.8	6.9
View of Program		
MCH	0.0	2.8
Medicaid	0.0	0.0
Total	0.0	1.4
Payment Delay		
MCH	0.0	5.9
Medicaid	0.0	13.2
Total	0.0%	9.7%

NOTE: N = 74 total agencies; 36 MCH and 38 Medicaid

SOURCE: National Governors' Association Survey of Provider Participation, 1988.

- Medicaid agencies reported greater concern among physicians with administrative issues, particularly with the complexity of forms.

These variations between Medicaid and MCH responses may also reflect the differences between the two programs. Since obstetrical providers have experienced the largest increases in malpractice premiums, it is probably not surprising that MCH programs would cite these concerns more frequently. The difference between agency and physician perceptions is interesting, and bears further examination. It may be that the agencies regard malpractice costs and low payment levels as interrelated issues, while physicians see them as distinct concerns.

2

The Literature on Physician Participation

Numerous studies have examined the physician participation issue. Before the results of the literature can be considered, several limitations should be noted.

- All of the studies identified in this research examined issues of private practitioner participation in Medicaid. No similar studies of public providers and participation in state Maternal and Child Health programs were located.
- Much of the data were collected in the mid- to late 1970s, although more recent reports have been published based on these data. A major exception is the study of pediatrician participation sponsored by the American Academy of Pediatrics in 1983, as a follow-up to an earlier 1978 study.
- The principal source of information on participation by obstetrician-gynecologists is the HCFA/NORC surveys of 1976-77. The other major studies examined participation by physicians generally, other primary care specialists (e.g., internists, general surgeons, pediatricians), or medical and surgical specialists.
- Studies use different definitions of "participation." One established a minimum Medicaid caseload as the definition of participation and excluded physicians below that minimum from the database, while another included all physicians, regardless of the number of Medicaid patients they served.

MAJOR FINDINGS OF THE LITERATURE ON PHYSICIAN PARTICIPATION

The research provides important information on the factors in Medicaid that affect participation.

Participation Rates

While physician participation in public programs varies significantly among specialties, participation among OB-GYNs has been relatively low.

National survey data used by Mitchell and Cromwell showed that 63.2 percent of OB-GYNs participated in Medicaid in 1976, compared to 77.4 percent for all physicians.[6] Only three of the identified specialties (allergists, cardiologists and psychiatrists) had lower participation rates. OB-GYNs also had

low average caseloads; only 8.3 percent of patients served were Medicaid recipients compared to 12.7 percent for all physicians and 13.3 percent for other primary care physicians.

Similar results were obtained in a 1974 survey in California.[7] Almost 12 percent of OB-GYNs reported serving no Medicaid patients, compared to 6.5 percent for all physicians. Only psychiatrists had higher rates of nonparticipation (13.8 percent).

As a group, medical specialists have been less likely to accept Medicaid patients than have primary care physicians.[8] Surgical specialists, on the other hand, have been more likely to serve persons covered by Medicaid. About 85 percent of surgical specialists accepted Medicaid patients, compared to 78.4 percent of primary care physicians. The difference between surgical specialists and OB-GYNs (85 percent compared to 63 percent) is particularly noteworthy, since obstetrics and gynecology are usually listed among the surgical specialties.

Medicaid Payment Levels and the Participation Decision

The relationship of Medicaid fees to levels of physician participation has been examined extensively. Generally, the higher the fees, the higher the participation rate.

In his studies of physician participation in California, Hadley defined participation as serving at least ten Medicaid patients per quarter. He found that a 10 percent increase in fees paid by Medicaid resulted in a 17 percent increase in participation and a 3 percent increase in Medicaid caseloads of participating physicians.[9]

Mitchell and Schurman defined participation as having any Medicaid patients at all. Their statistical analysis found that a 10 percent increase in fees resulted in 3 percent increase in participation among OB-GYNs.[10] Mitchell found a similar relationship in her study of medical and surgical specialists; a 10 percent increase in fees increased the probability of participation by 2.1 percent and swelled average caseloads by 3 percent.[11]

Two "natural experiments" reported by Gabel and Rice support these econometric analyses.[12] In 1976, physician fees in Carroll County in Maryland were raised significantly. A neighboring county where no fee increase occurred experienced a 9 percent reduction in participating physician practices between 1974 and 1978, while Carroll County had no reduction in participation. Held, Holahan, and Carlson examined the effect of California's increase in fees in 1976. They found that, holding all other factors constant, the increase in Medicaid payments increased the probability of participation among primary care physicians by 11 percent and increased average caseloads by 17 percent. For specialists, the respective rates of increase were 17 percent and 13.5 percent.

One study attempted to look at the effect of reducing fees. A 30 percent reduction in physician fees in Massachusetts in the 1970s did not lead to a significant reduction in surgery rates, except for tonsillectomies/adenoidectomies.[13] These data are not comparable to the previous studies, since they do

not examine provider participation in the program. Participation rates could have been reduced, but the remaining Medicaid physicians performed more procedures. Furthermore, the data include salaried as well as fee-for-service physicians, while only the latter were affected by the reduction in Medicaid fees.[14]

While levels of Medicaid fees are clearly critical determinants of physician participation, the data indicate that this relationship is not a simple one. The differential relationship between Medicaid fees, private insurance reimbursements and the physician's usual charge is equally, if not more, important to the participation decision. The higher a physician's private charge, the lower the likelihood of participation in Medicaid. Equally important, increases in private fees have been found to reduce Medicaid participation by a greater margin than the growth in participation that occurs when Medicaid fees are raised. In other words, the extent of the gap between low Medicaid fees and higher charges/reimbursements appears to dramatically affect the decision by physicians to participate in programs like Medicaid.

Hadley reported that a 10 percent increase in private fees reduced Medicaid participation by 19 percent and average Medicaid caseloads among physicians by 11.8 percent. In comparison, a 10 percent increase in Medicaid fees resulted in increases in participation of 17 percent and increases in caseloads of just 3 percent.[15]

Mitchell and Schurman arrived at similar conclusions in examining OB-GYNs specifically. Their data project that Medicaid participation would be reduced by 5.3 percent in response to a 10 percent increase in Blue Shield reimbursements.[16]

The Differential Influence of Medicaid Fees

The effect of reimbursements on participation varies, depending on the aspect of participation being examined and the specialty involved.

Both Hadley and Mitchell and Schurman found that reimbursement levels affected participation rates, but not caseload size. For OB-GYNs, Mitchell and Schurman found that fees were an important determinant of the dichotomous decision on whether to participate in Medicaid at all. However, once a physician decided to participate, the fee level had virtually no effect on the size of Medicaid caseload.

In her study of medical and surgical specialists as a group, Mitchell found that increasing fees increased participation rates and average caseloads.

Studies of participation among pediatricians by Perloff et al. examined differences between "full" and "limited" participants in Medicaid.[17] "Full participants" included physicians who said they would take all new Medicaid patients who contacted them, while "limited participants" were those who explicitly restricted their Medicaid practice. The ratio of Medicaid fees to usual and customary charges had a significant effect on full participants, but no effect on limited participants.

Taken together, the data suggest that a physician's threshold decision on whether to participate in Medicaid at all is strongly influenced by fee levels. Once a physician has decided to participate, however, the decision on how much to participate may be influenced by other factors.

Program Administration and Payment Delays

Another perennial complaint among physicians is the paperwork and time involved in obtaining Medicaid payments. Indeed, there are numerous anecdotal reports of physicians who serve Medicaid recipients, but do not bother to bill Medicaid at all. Two studies examining this question found higher participation where administrative problems were lower.

Mitchell and Schurman hypothesized that states using fiscal agents would process claims more rapidly. They found that participation rates were higher in states using fiscal agents – by 5 percent for OB-GYNs – and that Medicaid caseloads among participating physicians were also larger. While payment delays affected participation among all physicians, the effect was largest for OB-GYNs. They hypothesized that payment delays may pose particular problems for OB-GYNS since the long period over which pregnancy services are delivered means that the physician may not be paid for as much as one year. For other surgeons, in particular, the episode of illness is much shorter and payment can be received more quickly.[18]

Perloff et al. measured payment delays more directly, using data on elapsed time between billing and payment. Their survey of pediatricians found that payment delays significantly influenced Medicaid participation in both 1978 and 1983.[19] Quicker payment was associated with larger Medicaid caseloads among pediatricians who limited their Medicaid practices, but it had no significant effect on those who were full participants in the program.[20]

Medicaid Program Variables

Apart from provider payment, Medicaid program policies also have a significant effect on provider participation.

The studies of pediatricians used a composite index to measure "program generosity." The index includes (1) presence of a medically needy program, (2) number of optional services covered, (3) limitations and prior authorization requirements for basic services, and (4) reimbursement methods.[21] These studies showed that states with higher levels of "program generosity" experienced higher levels of participation (measured as percentage of physician's Medicaid caseload).

Mitchell and Schurman looked at the specific effect of limits and prior authorization requirements on OB-GYN participation. They found that the probability of physician participation in the program was higher where there were fewer limits imposed on services but that the presence of limits had no significant impact on the size of the Medicaid caseload for physicians who did participate.

Other Community Factors

All studies have looked at the relationship of various exogenous variables to Medicaid program participation. Factors ordinarily included are: the nature of the community in which a physician practices (e.g., proportion of the population receiving Medicaid or the level of per capita income in a given community; the country in which the physician was educated (i.e., whether the physician is a foreign medical school graduate); and the physician-population ratio. As might be expected, the studies find that participation is higher in areas where Medicaid recipients are a higher proportion of the population. Foreign medical graduates are more likely to participate than physicians graduating from American medical schools. The number of physicians in the community has been found to have an inverse effect on participation: the higher the physician-to-population ratio, the lower the participation rate.[22]

Mitchell and Schurman specifically examined the relationship of race to Medicaid participation among OB-GYNs. They found significantly lower Medicaid caseloads in counties where nonwhites were a higher proportion of the population; no such effect was found for general surgeons or pediatricians.[23] They note that these findings are only suggestive and the implications are unclear.

> Does this mean that OB-GYNs discriminate against nonwhite patients by not accepting them as Medicaid patients? Not necessarily—it may be that white patients discriminate by putting pressure on OB-GYNs not to treat Medicaid patients. It is also possible that the variable NONWHITE reflects some demand factors, such as ability to pay, not fully captured in our equation.[24]

They go on to suggest that the differences between OB-GYNs and general surgeons may stem from differences in the nature of the care they render. Surgical care involves short-term episodes, and therefore the behavior of these physicians (or their other patients) may be less sensitive to Medicaid patient characteristics.

Changes in the Factors That Influence Participation

The two studies of pediatrician participation deserve specific discussion because they demonstrate how the factors that influence the participation decision have changed over time. In 1978, pediatricians in thirteen states were surveyed about their Medicaid participation; the same sample was resurveyed in 1983. Comparison of the two years found the following:

- Overall participation rates among pediatricians changed little between 1978 and 1983, but average caseload size fell significantly.
- The factors with the greatest influence on participation changed during that time. The relative importance of Medicaid policy variables declined during the six-year period. The ratio of Medicaid payments to usual fees was a statistically significant variable in both years, but the level of significance decreased. The same was true of other Medicaid policy variables (e.g., program generosity).

- Community-related factors were more important in 1983 than they had been in 1978. Per capita income and the proportion of the population receiving Medicaid were significant in both years. In 1983, physicians in metropolitan areas and physicians in counties with high physician-population ratios were less likely to participate in Medicaid. Yet neither of these variables was statistically related to pediatrician participation in 1978.

IMPLICATIONS FOR STATE PROGRAM POLICY

Considered as a whole, the literature on physician participation has a number of implications for state policy and efforts to improve physician participation in perinatal programs.

1. Low participation among OB-GYNs is not a new phenomenon and the current obstetrician participation "crisis" may be the result of an exacerbation of previous problems. Lower participation among OB-GYNs may have been tolerable in the past, but new factors – rising malpractice costs, withdrawal of family practitioners from obstetrics, reductions in service by previously participating obstetricians – have altered the situation. The feeling of crisis is further intensified as states enact major OBRA-86 expansions of their public programs for low-income pregnant women.
2. The reasons for traditionally low rates of participation among obstetrician-gynecologists are numerous, unclear, and changing. While Mitchell and Schurman suggest that payment delays might be one explanation, the likelihood is that many factors, some unique to the practice of obstetrics and gynecology, also have been significant. Intriguing data from the 1976 HCFA/NORC surveys support this statement. Analyses of net revenue per patient visit showed lower revenue for physicians who participated in Medicaid – except among the OB-GYNs. OB-GYNs who did not participate in Medicaid had a net revenue per visit of $12.54, compared to $14.91 for those with small Medicaid practices and $13.32 for physicians with large Medicaid practices.[25]
3. The differential between public and private payment levels appears to be more important than the absolute level of public program reimbursements in influencing the participation decision. Since the literature indicates that equal percentage increases in private and public reimbursement levels can result in reduced participation, perhaps public program fees need to be increased at greater rates than private reimbursement levels to simply maintain, much less increase, provider participation.

   The differential between public fees and physician charges, as opposed to private insurer payments, is also important. Even if private insurers and public programs pay the same rate, the physician has the option of billing the private patient for the difference between actual reimbursement and submitted charges. Physicians also can require advance payments from

private patients, even when their charges are no more than private insurer reimbursements, thereby improving cash flow and reducing payment delays. Advance payments/deposits are increasingly common in obstetrical care.

4. The data on differential effects of fee increases suggest directions for designing state reimbursement policies. Reimbursement levels have a significant influence on the dichotomous decision of whether or not to participate in Medicaid at all. They appear to have a much lower effect on the size of caseload among participating practitioners. This suggests that raising fees across the board might be particularly appropriate in situations where participation rates, as an absolute, are low. Where the percentage of physicians participating is high and the average caseloads are low, a fee increase may be less effective as a tool for improving access.

   Once physicians choose to participate, they do so in different ways. The data on pediatricians suggest that fee increases might be effective in encouraging those physicians who have expressly limited the size of their Medicaid practice to become full participants and to take all possible Medicaid patients. Higher reimbursements would not, however, increase caseloads among those physicians who continue to restrict the size of their Medicaid practice. For these physicians, reducing payment delays appears a more viable policy strategy.

5. The factors that influence physician participation appear to be changing. The pediatrician studies indicate that while Medicaid policies are clearly important determinants, they are less important today than in years past. General market forces, outside the purview of the state agency, also are having a significant effect on physician participation. This may be particularly true for the OB-GYNs. For example, when Hadley examined the issue in the mid-1970s, he found no relationship between malpractice premium costs and participation. Today, a similar study would probably have different results.

3

The Changing Nature of the Participation Issue: Malpractice Concerns

Although provider participation has been a problem for years, the malpractice crisis has added a new dimension to an already difficult situation. Between 1982 and 1985, average premiums paid by all physicians for malpractice insurance rose 81 percent, from $5,800 to $10,500 per year.[26] Frequency of malpractice claims filed against physicians rose from 3.1 per 100 physicians prior to 1981 to 8.2 per 100 physicians between 1981 and 1984. In 1985, there were 10.1 malpractice claims per 100 physicians, more than three times the claims rate in 1981.[27] With the rising cost and incidence of malpractice claims, it is not surprising that 93 percent of respondents to the NGA survey – and all of the MCH programs – reported that rising malpractice costs were affecting provider participation in their programs.

The malpractice problem of the 1980s is quite different from the one that occurred ten years ago. During the 1970s, there was a "crisis of availability," as insurers withdrew from the medical malpractice market and physicians could not obtain insurance at any price. While some states experienced insurer withdrawal during the 1980s, the predominant problem has now become one of cost. Insurers now offer malpractice coverage, but at significantly higher premium rates.

Over the past ten years, virtually every state has enacted tort reform laws designed to reduce court suits and/or court awards and costs. The rationale behind these actions is that reducing the number of claims filed and the levels of awards will reduce malpractice premium costs. Typical tort reforms involve:

- limiting awards;
- establishing arbitration programs;
- limiting attorney fees;
- requiring periodic, rather than lump sum, payments on awards; and
- changing the statute of limitations for filing claims.

Just recently, the American Medical Association proposed that all malpractice actions be taken out of the court system and placed with state boards.[28] Both states and the federal government also have taken actions to strengthen and improve physician licensure and disciplinary procedures.

For the past ten years, the malpractice crisis has been addressed largely as an insurance and cost issue. Access to care has been an underlying concern be-

cause if physicians cannot obtain reasonably priced malpractice coverage, they may cease to provide certain services and/or serve particular population groups. However, the policy focus has been on tort reforms to mitigate, if not reduce, the increases in malpractice insurance premiums. The analytic literature on malpractice has focused on the effectiveness of these tort reforms on reducing malpractice claims and premium costs and not on improving access to care.

Sloan analyzed the impact of various changes in state laws on malpractice insurance premiums between 1974 and 1978.[29] He found no significant statistical effect of any reform – either individually or taken as a group – on premiums paid by physicians. Weak effects were found for certain reforms, including mandatory arbitration of claims. The most significant non- legislative factor related to malpractice claims was the lawyer-population ratio; Sloan found that states with more lawyers had higher malpractice premiums.

Danzon examined the impact of various legal reforms on the frequency of malpractice claims and the size of awards over a ten-year period (1974-1985) and found significant effects from several of the enacted provisions.[30] Changing statutes of limitations and instituting provisions to reduce awards by the amount of other insurance benefits obtained by a plaintiff have decreased the frequency of malpractice claims. Limits on total awards and provisions to offset other insurance reduced the size (or severity) of awards. Laws providing for binding arbitration appeared to increase the frequency of claims but reduce the total size of awards in malpractice cases. Danzon found no relationship between malpractice claims and the number of attorneys in a state, but did find that states with large urban populations had significantly higher malpractice claims and awards.

The literature on malpractice may be useful for states considering changes in their legal systems, but it does not provide much relevant information regarding implications of malpractice costs for physician participation in public programs and client access to care. The principal implication may be that reductions in malpractice claims engendered by tort reform take considerable time to be reflected in reduced premium costs. Danzon hypothesized that part of the difference between her findings and Sloan's was the time factor, since it would take some time for tort reforms to be reflected in claims payout and eventually in premiums. Only six state program officials who responded to NGA's survey (8 percent) believed that malpractice reform in their state had improved participation in their program. While tort reforms might help in the long run, they do not seem to offer much assistance in improving provider participation in the immediate future.

MALPRACTICE CONCERNS AND ACCESS TO OBSTETRICAL CARE

The rising costs of malpractice insurance have been particularly severe for OB-GYNs, whose premiums more than doubled between 1982 and 1985, compared to an 81 percent increase for all physicians.[31] Claims also increased, from 20.6

per 100 physicians annually in 1981 through 1984 to 26.6 in 1985. Claims per 100 obstetricians were 1.5 times greater than claims rates for all physicians, and significantly higher than for surgeons.

The most recent survey by the American College of Obstetrics and Gynecology documents continuing increases in malpractice premiums for these physicians. They report that the average premium paid by OB-GYNs in 1986 was $30,507, an increase of 46.5 percent since 1984. Premiums in 1987 rose to about $37,000, another 21 percent increase.[32]

Major increases in malpractice premiums are affecting all providers of maternity services. Family practitioners performing obstetrics are paying premiums twice as high as their colleagues without obstetrical practice.[33] Community health centers have seen malpractice premiums increase from $800-$900 in 1985 to $12,000 in 1986.[34] Certified nurse-midwives paid $3,500 premiums in 1985, compared to $800 in prior years – and premiums are expected to continue growing yearly for five years.[35]

There is no single comprehensive set of data currently available that documents a relationship between rising malpractice costs, declining provider participation in public programs, and access to care. Much of the available information is derived from anecdotal reports and/or single state studies.

MACRO Systems, Inc., reviewed the extent to which access to care was being affected by the malpractice crisis.[36] They found instances of reduced access in twenty-six states and potential access problems in another half-dozen, but could not document whether these were isolated problems or reflected broader trends. Primary sources of information were reports from national organizations and newspaper stories following local health care issues. They concluded that "there are no systematically obtained national data that define to what degree patient access to health care is being adversely affected by the current medical malpractice situation. There is evidence, however, that access is being impaired in some geographic areas and that certain population subgroups (e.g., low-income pregnant women) are being particularly affected in those areas."[37]

Numerous studies of individual states conducted by university researchers and state medical societies show declining obstetrical practices. In California, almost one-quarter of OB-GYNs have discontinued performing deliveries, or are considering doing so.[38] In Washington, 15 percent of OB-GYNs no longer perform obstetrics and fewer than half of general/family practitioners now practice obstetrics. Of the providers who continue obstetrical practice, 62 percent of OB-GYNs, 50 percent of general/family practitioners, and 37 percent of certified nurse-midwives limit the number of Medicaid patients they will serve.[39] In Maryland, 38 percent of OB-GYNs and 31.6 percent of general/family practitioners (compared to 17.3 percent of internists) reported cutting back on the number of high-risk patients and/or eliminating or reducing specific services. The service most frequently reduced by family practitioners was obstetrics.[40]

The NGA Survey of Provider Participation in Public Perinatal Care Programs adds to the growing body of evidence that access problems are aggravated by rising malpractice costs. Because the survey includes a response

from every state, except the District of Columbia, it may provide the broadest picture of the access problems, at least from the perspective of state agencies. As previously noted, thirty-five of the fifty states reported participation and/or access problems affecting their programs and 93 percent said rising malpractice costs contributed to the problem. As reported above, twenty-one states volunteered data showing that residents of at least 484 counties have limited access to services. Table 6 summarizes state reports of specific changes occurring as a result of malpractice issues.

- Ninety-three percent of all agencies reported that OB-GYNs in their states are dropping obstetrical practice. Eighty-seven percent reported similar events among family practitioners.
- Four-fifths of the respondents reported that many OB-GYNs are not taking new patients and 68 percent reported reduced care for high-risk patients.
- Three-fifths of the agencies reported that some physicians are ceasing completely to provide care to clients of public programs and almost 70 percent reported reduced participation.
- Few states reported that community health centers (CHCs) were eliminating obstetrical care or that hospitals were reducing emergency delivery services.
- MCH programs were more likely to report reductions in care by OB-GYNs to high-risk women (81 percent compared with 55 percent for Medicaid). Also, about four-fifths of MCH programs reported direct impact on physician participation in their programs, compared to about half of Medicaid programs.

Although written comments from respondents do not lend themselves to statistical tabulation, they do identify the direct effects of declining availability of public obstetrical care providers on access for low-income women. A number of states emphasize the need for women to travel long distances to obtain prenatal care. Lack of transportation prevents many women from getting early prenatal care. Others discussed the difficulties in caring for high-risk women when local providers are not available. Several states, particularly in the western and Rocky Mountain regions, mentioned patients traveling more than 100 miles for both prenatal care and delivery.

Largely because the malpractice crisis has been seen as a crisis in insurance, there has been little analytic research to date examining the relevant access issues. The growing concern about reduced availability of obstetrical care is generating new work that may help to clarify the issues. The Institute of Medicine, the American College of Obstetrics and Gynecology, and the National Commission to Prevent Infant Mortality have studies underway that may provide better information in the near future.

Table 6
Percent of Agencies Reporting Selected Changes in Availability of Obstetrical Care

	Maternal and Child Health	*Medicaid*	*All Agencies*
Providers dropping obstetrics			
OB-GYNs	97.2%	89.5%	93.2%
GP/FP	88.9	84.2	86.5
CHC	11.1	7.9	9.5
OB-GYNs not taking new patients	80.6	86.8	83.8
Physicians reducing participation	83.3	55.3	68.9
OB-GYNs reducing high-risk care	80.6	55.3	67.6
Physicians withdrawing from public programs	77.8	44.7	60.8
Hospitals reducing emergency delivery	11.1	13.2	12.2

NOTE: N = 74 total agencies; 36 MCH and 38 Medicaid

SOURCE: National Governors' Association Survey of Provider Participation, 1988.

MALPRACTICE-RELATED REASONS FOR NONPARTICIPATION

As malpractice premiums have risen, physicians appear to be less willing to provide obstetrical care to low-income patients. The reasons for this unwillingness include low payment rates, concern about caring for the high-risk, and the fear of lawsuits. According to state agencies, all of these factors are important. (See Table 7.)

- Eighty-four percent of responding agencies said that physicians "often" say that they do not participate because public program fees are insufficient to cover their malpractice costs.
- Just over half said that physician's often cite the higher risk of serving low-income patients, while slightly over one-third said that "the poor sue more."
- The proportion of MCH and Medicaid agencies citing low fees as a frequently given reason was nearly equal. MCH programs appear more likely to mention risk-associated reasons as the physician's explanation for nonparticipation due to malpractice concerns.

Table 7
Malpractice-Related Reasons Often Given by Physicians for not Participating in Public Programs
(Percentage of agencies reporting reason is "given often")

	Maternal and Child Health	*Medicaid*	*All Agencies*
Fees do not cover premium costs	83.3%	83.8%	83.6%
Poor patients are high-risk	63.9	48.6	56.2
Poor patients sue more	44.4	24.3	34.2
Poor patients do not get prenatal care and are high-risk	22.2	40.5	31.5
Cannot deliver patients not seen before	22.2	13.5	17.8
Cannot afford to give charity care	11.1	16.2	13.7

NOTE: N = 73 total agencies; 36 MCH and 37 Medicaid

SOURCE: National Governors' Association Survey of Provider Participation, 1988.

These various explanations for reduced physician participation fall into two categories, which are discussed below.

Rising Premium Costs and Low Public Program Reimbursement

The rise in malpractice premiums has provided renewed impetus for provider concerns over levels of public program reimbursement. The argument tends to be phrased in one of two ways: the simpler form is that fees are too low to cover the rising malpractice insurance costs. The more complex phraseology is that, with the higher cost of malpractice coverage, the provider must serve more private paying patients in order to cover increased expenses.

The fees that providers must charge in order to meet all expenses, including malpractice insurance costs, are difficult to ascertain. ACOG reports that in 1986 malpractice premiums constituted about 20 percent of a OB-GYNs overhead expenses. (Consistent data for earlier periods are not available.) In that same year, premiums represented 10.3 percent of a physician's gross income, compared with 9.7 percent in 1984.[41] While malpractice premiums rose 46.7 percent during the two years, the proportion of gross income devoted to malpractice costs rose just 6.2 percent.

Public programs generally pay providers at rates below the prevailing community charge for private patients. As previously noted, the literature has shown that the extent of this differential is a key factor influencing physician participation. Data from the NGA survey for thirty-six states indicate that in 1986, the

median state Medicaid program paid providers about 44 percent of the approximate community charge for total obstetrical care. The maximum was 76 percent of private charges while the minimum was 15 percent. (A more detailed discussion of Medicaid reimbursements appears in Section 4.)

A critical question for state agencies is: to what extent should Medicaid payments reflect the physician's full cost of malpractice coverage? In almost all states, malpractice insurance premiums do not vary according to the size of caseload. Particularly with physicians who have low Medicaid caseloads, one could argue that service to Medicaid patients is a marginal cost item and that payments which do not reflect full cost of coverage are not necessarily unreasonable. Along the same line, malpractice premiums include both obstetrics and gynecology, but Medicaid patients are more heavily obstetrical. If Medicaid reimbursement policies were to be revised to assume part of the cost of malpractice insurance directly, should these costs be adjusted to reflect Medicaid patients' utilization? Both of these questions are more applicable to physicians with small Medicaid practices than to those with large ones.

Fear of Suit

Costs of coverage appear to be only one aspect of provider concern. Nobody likes to be sued or defend his or her professional ability and reputation in a court of law. Obviously, there is a relationship between costs and risk, since premiums for all practitioners rise with the general increase in malpractice claims and awards. For the individual practitioner premiums will increase as a result of a single adverse judgment.

Review of anecdotal information and examination of the data suggest that a desire to limit individual risk of suit is a separate and distinct factor motivating physicians to reduce participation. Seven out of ten physicians reported to ACOG that they had been sued at some time in their career. The average physician reported one claim; 50 percent of the physicians had 1.7 claims or less. While the risk of being sued over one's lifetime is high, the risk of suit in any given year is relatively low. The GAO Closed Claims Study found that only 12 percent of OB-GYNs were involved in claims in a single year, and fewer than half of these resulted in any payment. Although the likelihood that an individual physician will, in a given year, experience an adverse malpractice judgment affecting his or her premium rate is low, 41 percent of OB-GYNs say they have changed their obstetric practice by reducing provision of high-risk care, decreasing deliveries, or ceasing obstetrical practice altogether.[42] This suggests that nonfinancial considerations, or "fear of suit" are important motives.

The relationship between service to low-income and/or public program patients and the risk of malpractice suits is comprised of several factors. Almost one-fourth of OB-GYNs report reducing their high-risk caseloads generally, a change affecting both women who are poor and those who are not. Since low-income pregnant women tend, as a group, to be at higher risk, providers may perceive that reducing services to this population is a direct method of risk management.

Another concern is continuity of service. The tabulated survey results do not indicate that physicians frequently say they cannot provide deliveries for patients they have not seen before. However, a number of MCH programs felt that one problem they experience is that the MCH program does not pay the delivery costs of patients who have received prenatal care from them. The author has been told of instances in several states where physicians were unwilling to deliver patients whom they had not previously seen for prenatal care, because they felt their exposure to a malpractice suit was greater in these circumstances.[43] These particular situations involved low-income patients who had received at least some prenatal care through local health departments.

Finally, there is the oft-mentioned belief that "the poor sue more." As indicated previously, about one-third of responding state agencies reported that physicians often give this as a reason for nonparticipation. To many analysts, the statement has appeared almost counter-intuitive. The literature show that the poor experience significant difficulties accessing legal services generally, and it is difficult to believe that this pattern does not apply in the malpractice arena as well.[44] Malpractice actions are normally brought on a contingency basis, where the plaintiff's lawyer receives a portion of the final settlement as a fee. Since settlements are often tied to lost earnings – and the poor earn less – settlements are lower, and there should be less financial incentive for attorneys to take these cases. In some instances, plaintiffs pay some costs up front (e.g., for preliminary research by the attorney). The poor are less likely to have financial resources available for this purpose.

The phraseology "the poor sue more" in itself raises many questions. First, who are "the poor"? Are they only the Medicaid population or does the term include all clients of public programs? Does the term refer only to unemployed low-income persons, or does it include the employed as well? It is unlikely that physicians are referring to persons with incomes below the federal poverty level, given the esoteric nature of that measure. References to "the poor" may be principally based on perceptions of patient income – perceptions that could be flawed. A comparison of physicians' estimates of their Medicaid caseloads with actual patient records found that the providers overstated the proportion of Medicaid patients by 40 percent.[45]

Second, what is meant by "sue more"? Does this mean that the poor sue more frequently, in an absolute sense, than the nonpoor? Or, does it mean that the poor account for more malpractice suits than the proportion of the population at risk? Do physicians believe that the poor bring frivolous court suits more frequently than the nonpoor? Alternatively, if the poor sue more frequently, is it because they are at higher risk of malpractice incidents than the nonpoor? It has been suggested that a doctor's perception that the poor sue more may reflect the psychological impact of a single court suit brought by a Medicaid or low-income patient.

Currently available data do not answer these questions conclusively and provide only limited information on the empirical issue of the relationship between income and malpractice claims. The data that are available span about 14 years (1973-1986); the earlier studies may not reflect the reality of today. Be-

cause the data on income or insurance status are exceedingly limited, studies that used other related variables (e.g., race, unemployment, per capita income) also are summarized below.

INCOME. The only study that looked at family income and malpractice is that of the U.S. Department of Health, Education, and Welfare's 1973 Commission on Medical Malpractice. This study did not examine claim or suit rates; it looked at individual perceptions that malpractice or "negative medical incidents" had occurred. The study concluded that higher perceptions of negative medical incidents were associated with higher income, educational level, and occupational status. Only 8 percent of persons with a negative incident considered seeking legal advice and only eight respondents actually brought a claim. Although no data were presented on claims by income, lower income respondents reported experiencing fewer "negative incidents" that might have led to legal action.[46]

MEDICAID. Several studies have examined insurance status and malpractice claims. The U.S.General Accounting Office examined a sample of malpractice claims closed in 1984 and reported data on malpractice claims and payout by insurance status.[47] Medicaid patients accounted for 5.8 percent of the closed claims for which insurance status was known; Medicaid recipients are about 9 percent of the total U.S. population. Almost 12 percent of the claims were by the self-pay–those without Medicaid, Medicare, private health insurance, or worker's compensation. About 17 percent of the U.S. population is estimated to have no health insurance.

The GAO found little difference in the proportion of claims settled with a payment: 51.9 percent for Medicaid claimants, 47.1 percent for the self-insured, and 50.5 percent for those with private health insurance. Both Medicaid plaintiffs and the self-insured received lower awards. The average total expected payout on behalf of a Medicaid plaintiff was $51,775; the average for the self-insured was $124,984. For the privately insured, average expected payment was $249,345.[48]

Unpublished data on malpractice claims in Maryland from 1977 through 1985 showed that Medicaid patients accounted for 9.6 percent of all claims for which insurance status was known; recipients represent about 9 percent of the state population.[49] Self-pay patients filed 17.1 percent of the malpractice claims, about the same proportion as are estimated to be uninsured in the state. Medicaid recipients accounted for 13 percent of OB-GYN claims for which insurance status was known. In 1986, Medicaid recipients accounted for about 19 percent of admissions to Maryland hospitals for obstetrical diagnoses.[50]

Weisman et al. examined malpractice experience associated with fertility-control services among a national sample of OB-GYNs.[51] They found no significant correlation between Medicaid participation and threatened or actual malpractice litigation.

The American College of Obstetrics and Gynecology surveyed a nationwide sample of hospitals. They found that "for all deliveries reported for respondent hospitals in 1982, no group of patients was significantly more likely to be a

litigant than any other group. While Medicaid patients represented only 17.1 percent of all 1982 deliveries and initiated 24.8 percent of all claims among respondent hospitals, this tendency did not achieve statistical significance."[53]

Providers responding to a survey in the state of Washington said that 26 percent of 366 reported malpractice suits had been initiated by Medicaid recipients.[52] They also estimated that Medicaid recipients accounted for 17.6 percent of their practices. However, those who authored the study have a number of questions about these results. Providers may have been reporting perceptions that may or may not be reflected in the actual claims experience. As stated above, some data demonstrate that providers often overstate the properties of Medicaid patients they serve. For this reason, plans are underway for a validation study using 1988 malpractice claims data.

RACE. A study in Cook County, Illinois, found that black plaintiffs accounted for 11 percent of all malpractice suits, though they comprised 23.5 percent of the county's population.[54] Weisman et al. found a negative correlation between malpractice risk and treatment of minority patients. Respondents who said they treated minority patients "fairly or very often" were less likely to have been sued than those who responded "rarely or never." On the other hand, the previously mentioned 1973 HEW study found that blacks were more likely to consider seeking legal assistance than nonblacks.

UNEMPLOYMENT. Danzon's study of the impact of tort reforms found no effect of state unemployment rates on frequency of total or paid malpractice claims; where the unemployment rate was higher, the frequency of late claims was lower. Neither Danzon nor Sloan found any relationship between malpractice claims/premiums and state per capita income.

In summary, the data now available do not support the conclusion that "the poor sue more"—but they do not disprove the belief either. The majority of studies using claims data from malpractice insurers indicate that the proportion of claims brought by Medicaid recipients are similar to or lower than the proportion of the relevant population receiving Medical Assistance. However, the data from providers (Washington state and ACOG) arrived at different results - although the higher litigation rate found in the ACOG hospital study was not statistically significant. Given the level of concern about this question and the methodological problems with the existing studies, further research is required.

IMPLICATIONS FOR STATE PROGRAM POLICY

States concerned with improving participation among obstetrical care providers must address the issue of malpractice costs and the perception of risk among obstetric providers. Ultimately, it matters little whether physician concerns derive from perceptions and beliefs or from objectively documented fact. The sense of risk in caring for low-income and/or high-risk women has assumed its own reality. Agencies will have to find ways to reduce this feeling in order to improve participation.

Fee levels will continue to be an issue. A number of states have raised their fees substantially over the past couple of years (see Section 4). It will be important to see whether, over time, these fee increases attract more physicians to the programs. The literature suggests that they should. However, if malpractice issues have altered the nature of physician decisionmaking, and reducing risk has become as important as payments levels, fee increases may be less effective than one would expect.

The available information clearly indicates that physicians are reducing public program participation in response to rising malpractice premium costs. It is not at all clear whether reducing malpractice premium costs will reverse this pattern. If physicians perceive themselves to be at greater risk of suit in serving low-income patients, malpractice premium costs could fall and participation would not necessarily be improved.

In developing new programs to improve care for women and children, state agencies might try to identify and address precise aspects of physician concern about risk. Some of the programmatic components of new initiatives to reduce infant mortality and implement OBRA-86 also may be important tools for promoting provider participation. For example, where physicians are concerned about assuring that they have complete knowledge of patient histories prior to delivery, improved coordination of prenatal and delivery services between MCH and Medicaid may be useful. Where physicians are particularly concerned about serving high-risk populations, agencies might consider structures that screen for risk status early. Physicians might be more willing to continue participating if agencies work out arrangements to assure that the majority of patient referrals are lower risk women. Case management programs, which are increasingly being included in state perinatal initiatives, could offer providers greater assurance that the broad range of services designed to reduce risk of unsatisfactory birth outcomes is being used by their patients.

State health departments and Medicaid agencies need to take an active role in the development of state policy regarding malpractice, to assure that access concerns are addressed. The responses to the NGA survey indicate that a large number of agencies have not been actively involved in these debates up to now. The prior focus on the malpractice crisis as an insurance issue needs to be broadened if agencies are to resolve their participation problems effectively.

4

State Initiatives to Improve Provider Participation

States are attempting to address the changing issues and problems of provider participation in a variety of ways. Table 8 summarizes the range of initiatives and proportion of agencies reporting implementation of program changes.

The NGA survey found that the most frequent approach adopted by states has been to increase the amount of money paid to providers for the delivery of services. Given the traditionally low fees paid by Medicaid for obstetrical (and most other) care, this focus on reimbursement is not surprising. Other significant efforts by states focus on directly recruiting providers into programs or, in contrast, developing more extensive relationships with alternative provider types, such as nurse-midwives. Interestingly, an entire set of initiatives that states predict may improve relations with providers has little, specifically, to do with the providers themselves. Expanding the pool of Medicaid-eligible pregnant women, implementing targeted case management or care coordination programs for pregnant women, and improving the coordination of eligibility, financing, and service delivery across state programs all hold promise to make Medicaid and other perinatal programs more attractive to the private provider community.

For the purpose of this discussion, state initiatives to improve provider participation are divided along the following lines.

- *Efforts to improve reimbursement* involve both the increasing of fees and the restructuring of reimbursement policies. Additionally, continued focus on the simplification of administrative procedures and billing remain a priority in specific states.
- *Efforts to enhance provider relations* range from specific initiatives to recruit new and/or alternative providers into public perinatal programs, to general program expansions and improvements which will, it is hoped, also make public programs more attractive to the provider community.
- *Efforts to limit the effect of malpractice insurance costs* on obstetrical providers aim to both utilize public funds to help cover providers' malpractice insurance costs and to limit legislatively the risk and liability faced by providers who choose to serve low income, public program recipients.

Table 8
Agency Initiatives to Promote Provider Participation Implemented Since 1985
(Includes only initiatives reported by at least 20% of respondents)*

	Maternal and Child Health	*Medicaid*	*All Agencies*
Raise fees	64.9%	74.4%	69.7%
Expand eligibility	51.4	57.9	54.7
Utilize case management	45.9	31.6	38.7
Use alternative providers	24.3	41.0	32.9
Improve coordination among agencies	32.4	28.9	30.7
New outreach/public relations efforts	27.0	28.9	28.0
Revise payment methods	21.6	31.6	26.7
Organized provider recruitment	29.7	23.7	26.7
Simplify billing	10.8	21.1	16.0
Provide malpractice insurance for MDs under contract	21.6	0.0	10.7

NOTE: N = 75 total agencies; 37 MCH and 38 Medicaid

*Includes actions reported by Medicaid and MCH agencies separately. In some cases, the state MCH program reported Medicaid fee increases and/or eligibility expansions (e.g., adoption of OBRA-86 coverage of pregnant women and children). For detailed discussions,these overlaps were edited, where possible, but the extent of overlap was not always clear.

SOURCE: National Governors' Association Survey of Provider Participation, 1988.

IMPROVING REIMBURSEMENT

Changes in reimbursement rates or policies are the most common approach used by the states. Three-quarters of Medicaid agencies and over three-fifths of MCH programs reported increases in fees between 1985 and 1987. About one-third of Medicaid and one-fifth of MCH agencies reported adopting new methods of payment. About one-fifth of Medicaid agencies have simplified their billing procedures; only two reported any sliding fee schedules for physicians.

Increasing Physician Payment Rates under Medicaid

Agencies were asked for detailed information on their 1986 fees for obstetrical and well-child services and their plans for fee increases in the future. After responses from both Medicaid and MCH agencies were combined, final tabula-

tions included data on Medicaid reimbursement rates for routine delivery and delivery by caesarean section for forty-one states; payment rates for prenatal, postpartum, and total obstetrical services were obtained for more than thirty-five states.

Table 9 provides summary statistics on Medicaid reimbursement rates. Details for each state appear in Appendix 2.

In 1986, the average Medicaid payment for routine delivery by an OB-GYN was $360 and the median payment was somewhat lower ($330). Reimbursement ranged from $795 in Maryland to $150 in New Hampshire. Average payment for delivery by caesarean section was $543, with Alaska paying $1,300, Nevada $917, and Maine $266. Maine and Rhode Island were the only states reporting the same reimbursement rate for routine delivery and caesarean sections, although several states had minimal differentials ($75 or less).

Prenatal and postpartum care averaged slightly under $20 per visit. The highest reimbursement for prenatal care was $55 for an initial visit and almost $90 for postpartum care; the lowest was $8. Payments for well-child visits averaged slightly more – about $25 – with similarly wide variations.

The national average for total obstetrical care in the thirty-three states reporting this method was $550, ranging from $1,508 in Massachusetts to $214 in New Jersey.

Most states pay physicians the same rates for specified services, regardless of specialty. Of the forty-one states reporting data, only Iowa, Nebraska, and New Jersey reported rate differentials for routine delivery by OB-GYNs and family practitioners. As a result, the average rates for routine delivery by family practitioners are slightly lower than those for OB-GYNs: $354 compared to $360. The differential in payment for total obstetrical care is somewhat greater: $44 higher for OB-GYNs.

A majority of states have increased reimbursement rates over the past several years. Thirty states reported that 1986 reimbursement rates were higher than their 1984 rates. Twenty reported that they plan to raise fees in 1987-88 and eleven of these provided detailed information on their new rate schedules. Among these states, rates for total obstetrical care are projected to increase 50 percent – from an average of $472 to $709. It is interesting to note that 43 percent of the states that had raised their fees between 1984 and 1986 planned to raise them again.

It has been noted frequently in this report that the differential between public program payments and charges to private patients is a more important determinant of participation than the absolute level of public payment. In order to assess the extent of this differential, states were asked for information on the "approximate community charge" for total obstetrical care. While the reported data are likely to be based on the state agencies "feel" for the community charge rather than any particular scientific survey, the information provides an indication of prevailing private payment levels.

Based on reports from forty-one states, the average national charge for total obstetrical care is $1,437 – ranging from a reported $3,500 to $675. The average Medicaid fee in 1986 was approximately 44 percent of the average national com-

Table 9
Medicaid Payments for Obstetric and Well-Child Services, 1986

	Average	*Maximum*	*Minimum*	*Median*	*Number Reporting*
Routine Delivery					
OB-GYN	$360.34	$795.00	$150.00	$330.24	41
Family/General Practitioner	354.14	795.00	144.00	328.64	41
Certified Nurse Midwife	321.42	795.00	112.00	286.06	33
C-Section	542.88	1,300.00	266.00	477.00	41
Prenatal Visit					
OB-GYN	19.21	55.04	8.00	17.50	39
Family/General Practitioner	19.10	55.04	8.00	17.50	39
Certified Nurse Midwife	17.77	44.00	7.00	15.00	29
Postpartum Visit					
OB-GYN	23.36	89.70	8.00	19.75	38
Family/General Practitioner	23.24	89.70	7.00	17.50	38
Certified Nurse Midwife	22.86	71.76	10.00	18.00	27
Total Obstetrical					
OB-GYN	550.52	1,508.00	214.00	519.00	33
Family/General Practitioner	506.49	861.30	210.00	501.98	32
Certified Nurse Midwife	448.11	861.30	165.20	448.00	25
Well-Child Visit					
Pediatrician	24.90	70.00	9.00	21.00	32
Family/General Practitioner	24.73	70.00	7.00	21.10	33
Certified Nurse Midwife	21.05	35.00	8.00	20.00	16

NOTE: Where a state reported fee for antepartum package, total was recalculated to per visit rate. If state provided number of visits assumed in package rate, that number was used. Otherwise, total fee was divided by ten visits to determine per visit rate.

SOURCE: National Governors' Association Survey of Provider Participation, 1988.

munity charge. In that year, the highest state payment rate covered 76 percent of the community charge, while the lowest covered 14 percent. (See Table 10.) Six states paid 30 percent of the average community charge or less–while five paid 60 percent or more. (See Table 11.)

Table 10
Medicaid Reimbursement Rates Compared to the Approximate Private Charge for Total Obstetrical Care, 1986

	Approximate Community Charge (41 States)	*Medicaid Payments as % of Community Charge (36 States)*
Average	$1,436.78	44.2%
Maximum	3,500.00	76.1
Minimum	675.00	14.8
Median	1,200.00	45.9

SOURCE: National Governors' Association Survey of Provider Participation, 1988.

Table 11
Distribution of States by Medicaid Payments as Percentage of Community Charge

Percent of Community Charge	*Number of States*
<30%	6
30-40	7
40-50	11
50-60	7
60	5

NOTES:
1. Summary statistics based only on states reporting on specific item.
2. Where state reported community charge as a range ($800-$1,200), the midpoint was used ($1,000).
3. Where Medicaid does not pay a total obstetrical fee (CPT-4 #59400), an equivalent reimbursement was calculated using obstetrician payment rates for (1) routine delivery, (2) 10 prenatal visits, (3) 1 post partum visit.

SOURCE: National Governors' Association Survey of Provider Participation, 1988.

It was possible to compare projected fee increases with the community charge for nine states. In these nine states, 1986 reimbursement rates averaged 38 percent of the community charge. After expected increases in 1987-88, they will be paying 57 percent–from 41 percent in Utah to 78 percent in Oregon. For states such as Florida and New Hampshire, fees were increased by well over 100 percent. (See Table 12.)

Table 12
Increases in Medicaid Reimbursement as a Proportion of the Approximate Community Charge for Total Obstetrical Care in Selected States

		1986		*1987-88*		
	Private Charge	*Medicaid Payment*	*% of Private*	*Medicaid Payment*	*% of Private*	*% Change in Medicaid Payment 1986-1988*
Arkansas	$1,000.00	$575.00	57.5%	$644.00	64.4%	12.0%
Colorado	1,200.00	510.00	42.5	700.00	58.3	37.3
Florida	1,800.00	315.00	17.5	800.00	44.4	154.0
Iowa	1,000.00	549.04	54.9	690.34	69.0	25.7
New Hamp.	1,000.00	214.00	21.4	450.00	45.0	110.3
Oregon	1,100.00	501.93	45.6	853.24	77.6	70.0
S. Dakota	675.00	325.00	48.1	500.00	74.1	53.8
Utah	1,700.00	519.00	30.5	700.65	41.2	35.0
Wyoming	1,200.00	553.50	46.1	787.50	65.6	42.3
Average	$1,186.11	$451.39	38.1%	$680.64	57.4%	33.7%

NOTE: Includes only nine states for which all data were available. It is not known how representative these may be of all states.

SOURCE: National Governors' Association Survey of Provider Participation, 1988.

While many states are increasing their fees to providers, some are more optimistic than others about the effects this will have on improving participation. For example, officials in Alabama and Kentucky believed that increasing fees would improve participation, while officials in Michigan and Pennsylvania felt that increases might only stabilize participation and not necessarily increase it. West Virginia found that increasing fees reversed previous declines in participation and "physicians, once again, [began] accepting Medicaid covered clients for maternity services." Pennsylvania commented that "increasing fees has done little to increase physician participation in [the] Medical Assistance Program. Despite two major increases in the past two years, participation has remained static."

This pessimism among state agencies is interesting, since the literature suggests that the sizable increases in Medicaid fees that are occurring should yield improved participation rates. One explanation is that, in many states, public programs began with such low reimbursement rates that even significant reimbursement increases could not catch up with private charges. The MCH program in Maine noted that "raising reimbursement rates did not help as cost of service continued to rise." Michigan commented that all it can hope to achieve is a preservation of, not an increase in, participation. "Raising fees seems to be positive, but fees are still so far below market rates." In Massachusetts, where

global fees are more than $1,500, the highest in the country, the MCH program said "overall. . .strategies appear to have limited impact on the total problem."

Changing Fee Structures

While new methods of payment adopted by states vary, there appears to be a trend toward allowing more "fragmented" billing procedures. Thirty-three states reported that in 1986 they had global billing (a method that pays providers a single fee for providing all obstetrical services – prenatal, delivery, and post-partum). In these states, between 13 percent and 100 percent of services were billed on this basis. Many of these states reported developing new options that break apart the global fee based on the theory that more flexible billing can better reflect the actual regimen and thus the cost of care provided, and result in more equitable reimbursement levels.

A number of states (e.g., Alabama, Kansas, Oklahoma, Oregon, and Virginia) have established a package rate for prenatal care, excluding delivery. The rates tend to be based on ten to fourteen prenatal visits over the nine months of pregnancy. Some (e.g., Kansas and Oklahoma) have a package rate per trimester to allow for variation depending upon when the woman entered care. Others reduce the total package rate if the woman begins prenatal care late in her term. One state has noted that this policy may be reevaluated – local physicians contend that it is just as expensive to care for a woman who enters prenatal care late. In fact, it may be more expensive if the delay has caused increased patient risk.

Some states have provided options of shifting from global to fee-for-service billing if the patient is referred to another physician. West Virginia, for example, enables physicians to choose global fees, per visit payments, or a prenatal care package.

Both Louisiana and South Carolina recently discontinued global billing for the total obstetrical package in favor of fee-for-service billing. South Carolina reported that such a move was actually more cost effective: "audit exceptions and large recoupment from obstetricians have convinced us that global OB should be deleted as a charge. All maternal care services must be fragmented." Reportedly, this change allowed the state to increase Medicaid fees without increasing expenditures. Kentucky recently rejected the global billing approach because of "administrative complexity taking into consideration the fluctuation in eligibility for Medicaid clients."

States are also adopting differential fee schedules which provide higher payment rates for particular services. A number of states (e.g., Colorado, New Hampshire, and New York) are paying higher rates for the first visit, to recognize the higher costs involved in initial diagnosis and assessment. Still other states have included "extra" payments if certain conditions are met. In California, for example, providers receive an additional $100 if they see a woman more than eight times on a prenatal basis. Further, if providers deliver services to a woman during her first trimester, they also qualify for an additional $50.

Both Florida and Washington have differential rates, based on the risk status of the patient. Washington began higher payments for high-risk deliveries in August 1985. When Florida raised its Medicaid rates in October 1987, the reimbursement schedule for obstetrical care was revised to differentiate between low and high-risk patients. Total obstetrical care for the low-risk patient is now reimbursed at $800; payment for the high-risk patient is $1,200. There are also differentials for routine delivery, caesarean sections, and antepartum care.

Some states pay higher rates to providers participating in special programs. New Jersey raised total obstetrical fees to $600 for physicians enrolling in the HealthStart program, but did not raise fee levels for physicians outside the program. Where special programs for maternal and child health services cover a broader range of services (e.g., nutrition, psycho-social, health education, or case management) as in California, Massachusetts, and Michigan, rates are effectively higher for enrolled providers.

Simplification of Billing Procedures

An ongoing complaint among physicians participating in Medicaid involves the complexity and inefficiency of state claims submission and claims payment procedures. Essentially, the argument follows that if fee levels are already low relative to community rates, the additional burden and inconvenience caused by an inflexible and problematic system through which these fees are reimbursed are significant disincentives to participation. Based on survey responses, nearly one-fifth of state Medicaid or MCH programs were undertaking efforts to simplify and improve billing procedures.

In California, for example, the claim processing system until very recently utilized a computerized process of sequential edits. Under this process, a provider's claim is "kicked out" of the system and returned to the provider for correction when the computer encounters the first error in that claim. Upon resubmission of the corrected claim by the provider, the computer then resumes its scanning of the bill. If another error is encountered, it is kicked out again. Such a process was resulting in cases where individual claims were having to be submitted and resubmitted five and ten times. Obviously, if such a claim was being submitted for a $10 prenatal visit fee, the provider's administrative cost of filing the claim far exceeded the eventual reimbursement received.

To alleviate this situation, the state has developed a new contract with a fiscal intermediary that will use a more logical system of edits. Under the new process, claims will be reviewed entirely by the computer and a complete list of any and all errors (if applicable) will be produced and returned to providers when claims are rejected. Upon correction of the errors, the system will complete the processing of the claim.

Realizing that problems surrounding the processing of claims were not all the state's fault, California has also begun training seminars for providers' staffs on how to fill out Medi-Cal claims correctly. Since the lower-wage clerical staff of providers most often have responsibility for submitting bills to Medi-Cal, the

state recognized that focused training sessions could result in the improved quality of submitted claims.

ENHANCING PROVIDER RELATIONS

Comprehensive program initiatives are being implemented by many states, particularly in the context of adopting expansions under OBRA-86. As of April 1988, twenty-two states had implemented poverty-level coverage options for pregnant women and children and another eleven had adopted programs scheduled to begin in 1988 or 1989. All but four set the eligibility threshold at 100 percent of the federal poverty level, and Oregon is scheduled to raise eligibility in October 1988. Numerous states commented that expanding eligibility will, in and of itself, improve provider participation by increasing the pool of women who possess insurance coverage.

Other sub-options within OBRA-86 also hold promise to improve participation. The option that allows for continuous eligibility of recipients, for example, regardless of fluctuations in income (adopted by twenty-seven states) may be particularly important since it helps assure physicians that Medicaid reimbursement will continue to be available throughout pregnancy through the sixty-day postpartum period. Similarly, the option to permit short-term, presumptive eligibility to recipients while Medicaid applications are being reviewed (adopted by sixteen states) guarantees that Medicaid reimbursement will be available for at least part of the prenatal period.

Another important aspect of many new program initiatives is that they emphasize increased coordination between Medicaid and MCH programs. Some states (e.g., West Virginia) have required the coordination of both services and funding in their enabling legislation.[55] In addition to obvious advantages of coordinating patient care, two elements deserve mention as provider recruitment tools. One is that these efforts offer potential for better relating MCH-provided prenatal care with Medicaid payment for deliveries, thereby reducing physician concern about financial exposure or potential charges of abandonment. Another is that, in some areas, MCH programs may have a better "public image" than Medicaid so that coordinated programs offer an opportunity for improving perceptions of the programs among providers.

As states implement broadened programs, they will need to consider carefully the potential interaction among various program components. For example, expanding coverage may actually reduce the effectiveness of strategies to promote improved provider participation by increasing fee levels. One state commented that they raised fees 10 percent at the same time that eligibility was expanded, which resulted in a similar percentage increase in recipients. The two initiatives virtually cancelled each other out; although provider participation went up, the ratio of providers to recipients remained static.

Table 13 illustrates the range of initiatives states are undertaking to increase provider participation by enhancing both program design and relations with

providers. Two specific approaches discussed below focus directly on providers and appear to be of particular interest to states.

Table 13
Percent of Responding Agencies Reporting Initiatives to Increase Provider Participation

	Implemented	*Considering*	*Implemented Before 1985*
Comprehensive Program Improvements			
Expand eligibility	54.7%	21.3%	1.3%
Implement case management	38.7	30.7	2.7
New outreach/ Public Relations Efforts	28.0	20.0	4.0
Provider expansions			
Broader use of alternative providers	32.9	15.8	23.7
Utilize hospital residents	9.3	2.7	21.3
Provider recruitment			
Engage in voluntary efforts with medical society	21.3	20.0	13.3
Conduct organized provider recruitment	12.0	14.7	9.3

NOTE: Percents do not total to 100% because all responses are not included.

SOURCE: National Governors' Association Survey of Provider Participation, 1988.

Using Alternative Providers

Given the persistent low rates of participation among OB-GYNs, many states have actively pursued efforts to increase their use of alternative provider types. Many states want to expand use of certified nurse-midwives and other professional practitioners in maternity care programs. More than half have already implemented such endeavors, either by broadening Medicaid reimbursement policies or by staffing MCH programs, and another 15 percent are considering such programs. For example, in Florida, county health units are increasing their use of nurse-practitioners and nurse-midwives. One respondent summed up the general interest: "Nurse-midwives: great! Wish we had more."

States can expand use of alternative providers either as employees of state and local health units or through Medicaid reimbursement policies that encourage participation by the private sector. Federal Medicaid law requires that states cover services by certified nurse-midwives to the extent that these practitioners are licensed under state law. Thirty-three states reported payment rates for routine delivery by certified nurse-midwives and twenty-five reported rates for total obstetrical care. Eighteen of these states (55 percent) pay the same rates to certified nurse-midwives as they do to physicians. In the other fifteen

states, payments to certified nurse-midwives average 76 percent of the OB-GYN rate for total obstetrical care and 90 percent of the physician rate for routine delivery and prenatal services. Fees vary considerably. One state paid CNMs 55 percent of the physician rate; another paid 90 percent. (See Table 14.)

Table 14
Medicaid Payments for Services by Certified Nurse-Midwives, 1986

All Reporting States	*Physician*	*Certified Nurse-Midwife*	*Percent of Physician Fee*
Routine Delivery			
Average	$356.21	$321.42	90.2%
Maximum	795.00	795.00	100.0
Minimum	150.00	112.00	74.7
Prenatal Visit			
Average	$19.07	$18.16	95.2%
Maximum	55.04	44.00	79.9
Minimum	8.00	7.00	87.5

NOTE: N = 33

SOURCE: National Governors' Association Survey of Provider Participation, 1988.

When considering initiatives to expand services by nurse-midwives, several potential constraints need to be recognized.

- The number of certified nurse-midwives is relatively small and they have tended to practice in limited geographic areas. In 1982, there were 2,550 certified nurse-midwives in the United states. According to a survey by the American College of Nurse-Midwives (ACNM) in that year, 65 percent were in clinical practice. Almost one-quarter of practicing nurse-midwives were in Connecticut, New Jersey, New York, and Pennsylvania. Another 17 percent were in the Far West (Alaska, California, Hawaii, Oregon, Washington) and 15 percent were in the southern states (Alabama, Florida, Georgia, Mississippi, North Carolina, and South Carolina).[56]
- The number of unemployed certified nurse-midwives who might be attracted to state programs is also low. According to the ACNM survey, about 12 percent of all nurse-midwives were unemployed in 1982. Of these, about 18 percent said they wanted to work but no nurse-midwife positions were available in their community. Thus, state agencies interested in expanding use of nurse-midwives must explore ways of attracting the currently employed to public programs and/or competing with the private sector for this personnel.
- While the ACNM certifies personnel throughout the country, scope of practice in a particular area is defined by state licensure laws. As of 1987, five states did not authorize certified nurse-midwives to sign

birth certificates in all situations; only eighteen gave prescriptive authority to these providers.[57] States interested in expanding their role may need to reexamine their licensure laws.

- Certified nurse-midwives handle low-risk, not high-risk deliveries and practice in collaboration with physicians. Thus, use of certified nurse-midwives may reduce reliance on physicians for ongoing patient monitoring, but does not replace the need for physician participation. In the current malpractice environment, this raises two related issues that must be addressed. One state agency noted that they had recently implemented a reimbursement system for nurse-midwives but that, because state law required a midwife to work in conjunction with a physician, physician concerns about their potential liability might limit availability of this new practitioner. The Michigan MCH program funded two projects to develop certified nurse-midwife clinics. They reported that one was successful, but the other was not, due to physician resistance. The second issue is that, in their private practice, physicians may carry malpractice insurance surcharges because they work with certified nurse-midwives. The recent ACOG survey reported that only 7.7 percent of physicians had certified nurse-midwives in their offices and almost half of them had to pay a malpractice insurance surcharge for this position.

Organized Provider Recruitment

Increasingly, direct efforts to recruit physicians into public programs have been undertaken by states. In some instances, it appears that providers respond very favorably to personal contact by state officials, alleviating existing frustrations with the previously "faceless" bureaucracy. Nearly one-fifth of state agencies responding to the NGA survey report some active physician recruitment programs. Recruitment approaches were divided into two types: promoting voluntary efforts with medical societies and increased direct agency recruitment of providers. Methods of recruitment vary and appear to be tailored to particular situations and conditions in localities and states.

ONGOING PROVIDER RELATIONS. A number of states have developed ongoing relationships with medical societies, which serve as both a channel of communication and as a means of discussing and resolving specific problems. The Michigan MCH program has ongoing activities with the state medical society to identify and resolve problems in areas with an inadequate number of physicians, or none at all. The Michigan Medicaid program also publishes a newsletter for providers in order to promote ongoing communication. The state of Utah believes that these ongoing relationships are their most effective means of resolving participation concerns.

CRISIS RESPONSE. Over the past couple of years, a number of state agencies have faced situations in which current providers have withdrawn from program participation and either MCH or Medicaid clients have been left

without access to care. Efforts to deal with such situations are specifically related to the unique local problems at the root of the crisis and are characterized by intensive involvement of staff with providers.

In Arkansas, the Medicaid agency engaged in intensive one-on-one work with physicians in one local community to resolve a critical lack of participating doctors. These efforts included individual discussions between physicians and Medicaid agency staff, clear definition of initiatives to address the particular problems of local concern, and ongoing contact between the state agency and the local physician community. One interesting element of the Arkansas effort was that providers were told to send bills directly to an identified individual in the state office; this official was responsible for monitoring their progress through the payment system. Program staff commented "the following combination seems to work best for us: (1) intense provider relations efforts one-on-one; (2) attention to prompt payment of claims; and (3) raised reimbursement rates."

In Maryland, several local health departments and/or hospitals faced varying problems in assuring continued physician participation for prenatal care and delivery. The state agency attempted to facilitate solutions appropriate to each locality by working with the medical society, hospitals, and local providers and agencies. In one county, after open negotiations, hospitals agreed to contract to provide staff for health department clinics that had experienced discontinuance of obstetrical services. In another, the county government provided additional budgetary support to a cooperative program between a private physician group and a local hospital. In another situation, the local hospital arranged to employ physicians who were planning to stop obstetrical practice in order to pay their entire malpractice premium.

ORGANIZED RECRUITMENT EFFORTS. Many of the organized, ongoing recruitment efforts appear to be related to the initiation of new programs. Some states believe that targeting recruitment to new programs is more effective because the new program does not always carry with it the problem-laden aura providers have previously experienced.

California uses local health department coordinators in each county to recruit providers for participation in the Comprehensive Perinatal Services Program. Among other activities, these coordinators operate speakers bureaus available both to local physician organizations and hospitals as a means of promoting recruitment. To promote involvement of private practice physicians, intensive seminars have been held across the state in an attempt to demonstrate the economic feasibility for the individual physician of participating in the states' new program of enhanced prenatal care. When West Virginia adopted their comprehensive program for maternal and child health in 1987, they conducted "door-to-door" recruitment, meeting with individual physicians in their offices as well as with local physician groups. New York has launched an aggressive statewide publicity campaign and a marketing effort to physicians and HMOs, an effort that includes meeting with district ACOG members to promote enrollment in their Perinatal Care Assistance Program. When Massachusetts began the Healthy Start program, they held over forty meetings with advocacy

and provider groups over a two-month period and had 300 participating providers when the program began on January 1, 1986.

MONITORING PROVIDER PARTICIPATION. Some states try to monitor changes in provider participation, either on an ongoing basis or with the use of surveys. Some states (Illinois, Michigan, Washington) have done special studies to identify provider concerns and/or issues in provision of maternity care. Illinois, for example, used birth certificate data and a special population survey to identify problems in prenatal care. Michigan and Illinois surveyed physicians to identify reasons providers do not enroll in Medicaid and the problems of concern among currently participating physicians.

Accurate methods for tracking provider participation are difficult to develop given the weaknesses of the available provider data. There are some interesting approaches developed by states that can be used as indicators to identify geographic areas with participation problems.

- South Carolina has developed data by county on Medicaid recipients per participating physician. Although the provider information may suffer from some of the weaknesses inherent in all these data (e.g., duplicate billing numbers, no measure of caseloads per physician), they provide a means of comparing counties to a statewide average and tracking changes in availability of physicians within each county over time.
- Nebraska's health planning and Medicaid agencies jointly developed data on the distribution of all physicians (Medicaid-enrolled and active participants) and Medicaid recipients, per physician. As in South Carolina, these data provide indicators of problem counties where programs might focus attention and allow for monitoring changes as they occur.
- Arkansas has used Medicaid data on the delivery of provider bills to identify counties that have Medicaid recipients, but no Medicaid deliveries over a defined period of time. These data identify potential problem areas that merit further investigation to determine whether there are participation or access problems in particular geographic areas.

LIMITING THE EFFECT OF MALPRACTICE COSTS

Only a few states have attempted to address the access component of malpractice issues directly. The activity that has occurred is almost totally among the MCH programs. About 20 percent of the MCH programs reported that they provide coverage for physicians working for the public programs. About 13 percent are hiring more physicians as state and county employees, rather than contracting with private practitioners. (See Table 15.)

Table 15
Percent of Responding MCH Agencies Reporting Malpractice Initiatives

	Implemented	*Considering*
Providing coverage for MDs under contract	21.6%	10.8%
State paying costs directly	13.5	18.9
State employing MDs	13.5	16.2
Limiting MD liability	5.4	10.8

NOTE: Percents do not total to 100% because all responses are not included.

SOURCE: National Governors' Association Survey of Provider Participation, 1988.

Covering Malpractice Costs with State Funds

There are a few, very limited experiments in using public funds to assist providers with malpractice insurance costs. In Michigan, a small demonstration project, jointly sponsored by the Department of Health and the Medicaid Program, was developed to pay physicians $100-$200 per client to help offset malpractice premium costs. Medicaid reports that the payments are not eligible for federal matching funds. Similarly, a few individual counties are providing local dollars to subsidize state payment rates and encourage physicians to continue service.

In 1986, the Arkansas legislature appropriated $250,000 for each of two years to address issues of malpractice insurance. The MCH program proposed that the funds be used to create a system of regionalized obstetrical care and risk reduction education. The underlying concept is that developing guidelines and methods for patient risk assessment and referral to appropriate providers should result in better patient outcomes and reduced liability claims. The proposal was approved in December 1987.

Legislative Approaches to Malpractice and Access

In the context of malpractice reform, several states have enacted legislation of particular importance to the access issue.

Virginia was the first state to adopt "no-fault" liability coverage for birth-related neurological injuries to newborns. The program takes a defined set of severe injuries out of the tort claims process, and provides for payments through a workers compensation-type system. Participation is voluntary for both physicians and hospitals, who pay fees to support the compensation fund. The Virginia statute has been looked on as a model for other states. (Florida became the second state to adopt the approach in its 1988 malpractice reform legislation.) As of January 1988, over 50 percent of the OB-GYNs and forty hospitals with obstetric practice were participating in the plan.

In addition to the potential for reducing malpractice claims and premium rates, the Virginia statute has specific provisions to improve access. The law requires that physicians participating in the program also agree to "participate in the development of a program to provide obstetrical care to patients eligible for Medical Assistance Services (Medicaid) and to patients who are indigent, and upon approval of such program by the Commissioner of Health, to participate in its implementation."[58] While such language embodies an intriguing "quid pro quo" for OB-GYNs and other providers, it remains to be seen how this plan will actually be implemented.

Missouri has adopted a program that covers malpractice claims against physicians contracting with local health departments under the state's general liability fund for its employees. The statute provides that the state Legal Expense Fund, which is funded with appropriated general revenues, will cover claims against physicians "providing public health services without compensation or with minimal compensation to patients for medical care caused by pregnancy, delivery and child care under contract or employment agreement with a city or county health department."[59] The statute covers physicians contracting directly and those working for hospitals with contracts with local health departments. Given its constraint to cover claims against physicians receiving little or no compensation, this statute will not apply to Medicaid providers.

The effectiveness of these statutory attempts to address malpractice and access issues simultaneously will depend, ultimately, on their implementation. There are numerous questions that will need to be resolved in the coming years.

- In Virginia, there has been considerable debate over the operational definition of the statutory language regarding access. For the first year of implementation, the participation agreement specifically states that participation in Medicaid is not required, and that the obligation to participate in implementation of a program will be defined in future years. Discussions with individuals in the state indicate that concern about mandatory Medicaid participation is a major issue to physicians.
- The response of malpractice insurers – and the extent to which these new programs will reduce premiums for physicians – is an issue in both Missouri and Virginia. The Missouri statute specifically says that a physician's private malpractice coverage "shall not be considered available to pay claims arising from such physician's services." The Virginia statute, by definition, takes an established set of potential injuries out of the tort system insured against by malpractice coverage. In both states, physicians covered by the program should have lower risk of paid malpractice claims. Apparently, the question of adjusting premiums for these physicians to recognize their reduced risk is still open. As of January 1988, malpractice insurers had not adjusted rates in either state, although the Insurance Commission in Virginia was looking into the issue.

- As with any new program, detailed implementation issues frequently emerge after legislation has been enacted. In Missouri, one immediate concern was the definition of "minimal compensation," eventually set at 85 percent of the Medicaid payment rate. Other specific issues relate to occasions when physicians are covered under the state's program. These questions derive from the legislative drafting. For instance, is there coverage under this program for a hospital-employed physician who personally receives more compensation than the Medicaid rate, but whose hospital has contracted with a county to provide services at lower cost? These and similar questions may appear esoteric, but the ultimate success and perceived fairness of the program may depend, in part, on their resolution in legislation or regulation.

Conclusions

The problems and issues identified in this report have no easy answers. The malpractice issue has its roots in fundamental legal, medical, and social problems that state Maternal and Child Health and Medicaid programs cannot resolve directly. Yet, the agencies experience the effect of these concerns when they try to improve programs, implement new initiatives, and otherwise meet their responsibilities for assuring care for low-income women and children.

The options available to states for improving participation also appear limited. Increasing fees, restructuring reimbursement policies, simplifying billing, and intensive recruitment and marketing efforts may be the primary approaches available for the short term. Expanding program options, developing relations with alternative providers, and the malpractice-related legislative approaches hold potential for the future. As agencies plan for recruitment in the future, several additional thoughts might be considered.

- Agencies should carefully examine the potential of using new programs as major recruitment devices. Assuming it is true that obstetrical providers are increasingly risk-averse, case management programs, continuous eligibility, and expanded benefits (like nutrition counselling) should be attractive. Most of the literature provided by states in response to the NGA survey stress these programs as efforts to improve health care for women and children. Provider recruitment materials might stress their effectiveness as risk management tools.
- The number of states that have increased reimbursement rates significantly for physicians allows for a "real life" assessment of their effectiveness in improving participation in today's climate. If the findings of the literature continue to be valid, states that have significantly increased fees and reduced the differential between private charges and public payments should experience sizable increases in participation. On the other hand, if the "fear of suit" has become an overriding consideration to obstetrical providers, fee increases will probably be less effective. The importance of understanding the changing determinants of physician participation is probably self-evident. State agencies could expend substantial financial resources in their efforts to improve participation. If fee levels per se have become less important in today's environment, those resources might be better used in other ways.

- Routinely maintained participation data do not provide accurate indicators of the extent of physician involvement or access to care. Appendix 1 discusses in greater depth some of the problems with current participation data. It is important to remember, however, that participation data derive from state operating systems which, appropriately, are designed to manage day-to-day program needs – not to provide data for health services analysis. Rather than expending time and resources to develop better counts of participating physicians, state agencies might explore the use of indicators that could quickly and routinely be used to target geographic localities with problems. Developing methods of tracking changes in billing patterns – like reductions in claims for prenatal services – would probably be easier and might even be more useful for programmatic purposes.

These and similar questions are likely subjects for future research and evaluations. Unfortunately, many state programs appear unable to wait on such research results. The participation problems they experience – and the potential effect on nationwide efforts to improve maternal and child health status – call for immediate attention to and resolution of this issue.

APPENDICES

Appendix 1

Data on Provider Participation

The NGA survey included questions on the number of participating providers in MCH and Medicaid programs. Reported data were inadequate to use in the analysis. This appendix discusses some of the problems with the participation data.

MATERNAL AND CHILD HEALTH AGENCIES. Data were requested on the number of full-time and part-time employees and private practitioners rendering service paid for by the programs. Many of the state agencies contract with private organizations or with local health departments to provide MCH services with Title V monies. As a result, most of the responding state agencies did not have data on the number of providers participating in local programs.

MEDICAID AGENCIES. These agencies were asked to provide data on participating providers in 1984 and 1986. In addition to total counts, data were requested by specialty (OB-GYN, family or general practitioners, pediatrician and certified nurse-midwife). States were also asked for information on the number of providers billing more than $1,000 during the year.

Only twenty-five of the responding Medicaid agencies provided participation data for 1986; of these, sixteen provided data by specialty. For 1984, sixteen provided total participation data, and only seven provided information on the number of participating OB-GYNs. Very few of the states could provide information on the number of physicians billing more than $1,000.

Table 16 shows the reported participation data for 1986. Five of the sixteen states with OB-GYN participation data report more physicians than the American Medical Association (AMA) reports are in the state. In some of the other states, participation rates seem quite high. Comparison of reported Medicaid participants with AMA data shows four states with more than 80 percent participation rates. In some cases, the reported total number of participants was much higher than total doctors in patient care in the state. This may result, in part, from a flaw in the questionnaire. Because the survey concerned physicians and nurse-midwives, the term "providers" was used, rather than "physicians." Analysis of the results indicates that some states reported all providers (including, for example, hospitals). This would not explain the differences in data by specialty, where the question was asked specifically.

Discussion

Data on physician participation in Medicaid derive from state operating systems whose primary purpose is to pay claims. These systems are appropriately structured to achieve their primary purposes. The problems with participation data, while disturbing to analysts, derive from the nature of the operating systems.

Table 16
Analysis of Data Reported on Participating Providers, 1986

State	*Total Physicians Participating*	*OB-GYN Participants in Medicaid*	*OB-GYN Total in State*	*More Participants than MDs*	*Percentage of MDs Participating*
California	30,713	2,031	3,715		54.7%
Ohio	29,661				
Texas	28,729	968	1,804		53.7
Illinois	25,181				
New York	23,470				
Iowa	21,377	919	170	Yes	
Louisiana	17,143				
Missouri	16,790				
Kentucky	15,627	691	348	Yes	
Michigan	10,844				
Connecticut	10,186	337	538		62.6
Wisconsin	9,980	493	421	Yes	
Florida	7,644	312	1,396		22.3
Virginia	7,079				
South Carolina	7,000	290	342		84.8
Tennessee	5,325				
Alabama	5,264	178	398		44.7
Kansas	5,043				
Hawaii	3,091	141	166		84.9
Nebraska	2,326	559	126	Yes	
Rhode Island	1,436	66	128		51.6
South Dakota	1,330	35	40		87.5
Vermont	1,314	55	64		85.9
Nevada	1,200				
Delaware	1,177	94	86	Yes	
Arkansas		255	183		
Total States Reporting	25	16	16	5	

NOTE: Physicians in state include all MDs in patient care.

SOURCE: AMA physician characteristics and distribution in the U.S., 1987.

- Multiple provider numbers: This may be the primary explanation for the apparently inflated count of participants. Physicians may use different provider numbers for different locations in which they provide care (private office, health department, hospital). Most state systems do not require a single provider number and most states do not have a unique identifier, accessible to the Medicaid agency, which would allow linking multiple Medicaid provider numbers to a single physician.
- Date of bill versus date of service: Operational billing systems track bills received and paid, not the date when services were rendered. Services rendered in one year may be paid in another. The physician may no longer be participating or may have retired or left the state, but the bill will result in his or her inclusion in the count of participating physicians.
- Out-of-state providers: Some physicians are located in one state but serve Medicaid patients from another and have a provider number for that state's Medicaid program. The extent to which this circumstance can inflate a state's participating provider count so that a state appears to have more providers than physicians varies, depending upon geography and care-seeking patterns. Some states use different provider numbers for out-of-state providers and can disaggregate them while others do not.
- Information on specialty: It is not surprising that many of the states which could provide participation data did not have this information by specialty. For payment purposes, a physician's specialty is not particularly relevant. Indeed, many state medical licensure boards do not have such information. Furthermore, the definition of "specialty" is not entirely clear. Apart from board certification, a physician's specialty may be the subject in which he or she concentrates practice--a form of self-identification.

The problems with participation data would suggest that efforts be made to establish a better base-line on participating physicians. This would be best done by the state Medicaid directors, who are most familiar with the specific problems. It may also be that some states have solved problems like multiple provider numbers, out-of-state providers, or the intricacies of linking individual providers with volumes of billing. It should be noted, however, that such an effort would be time-consuming and expensive and may prove impossible. North Carolina Medicaid has been engaged in such an effort for almost two years. In the opinion of staff, the problem of multiple provider numbers cannot be resolved without major changes in the system, including a unique physician identifier.

Another approach might be to try to develop indicators of changes in access due to participation, rather than trying to improve the participation data itself. Changes in the number of Medicaid deliveries, or Medicaid-financed prenatal care, might be tracked on a small-area basis (e.g. county), as Arkansas

has done. This information might be routinized to highlight potential problem areas. For example, counties which have Medicaid recipients but no Medicaid deliveries over a six-month period might be flagged for examination. Further exploration might indicate that normal care-seeking patterns in that area meant that all patients went to a neighboring town in another county--or it might indicate that there was a serious participation problem.

Appendix 2

Methodological Notes on Medicaid Reimbursement Rates

The NGA survey requested financial data for Medicaid and Maternal and Child Health programs. Many of the state MCH programs contract with local agencies or provide Title V funds directly to local health departments for the provision of services. In many cases, where private physicians render services to MCH patients, specific rates of payment are locally established. As a result, the reported MCH data were insufficient for use in the analysis.

Table 17 provides state-level detail on reported Medicaid reimbursement rates for obstetrical care and well-child visits. Wherever possible, data were reported in the form provided by the state agency. Editing was required, in some cases, to assure consistency. The methodology used for developing both the state-level detail and the summary text tables is discussed below.

1. A total of forty-three Medicaid agencies responded to the survey. Only a very few Medicaid agencies were unable to provide data on fees. Data on routine delivery fees cover forty-one states; total obstetrical fees cover thirty-three states.
2. In a very few cases, a state Medicaid agency did not respond to the survey, but the MCH agency provided some information on Medicaid fees. For these cases, the information from the MCH agency was used.
3. Some respondents provided reimbursement rates for an entire antepartum package, not for separate prenatal visits. To provide for consistency of data, the package was broken down into a single visit rate. Where the respondent reported the number of visits included in the package, the total fee was divided by that number to determine a per visit rate. If the state did not give a specific number of visits, ten was assumed.
4. A few states reported differential rates for initial and later prenatal visits. The later prenatal visit rate was used. The data were edited, to the greatest extent possible, to assure that prenatal visit fees did not reflect higher initial visit payments. It is possible, however, that this editing was not entirely accurate. Any such inadvertent error would not affect the summary statistics significantly because only very few states could have been involved.
5. Where state agencies reported geographic variation in fees, the mid-point was used.
6. States were asked for "the approximate community charge to private patients for total obstetrical care." Where both Medicaid and MCH responded to the survey, the reports were combined, and the mid-point was used. In most states, the two agencies did not differ by more than $400-$500,

Table 17
Medicaid Provider Reimbursement Rates, Reporting States, 1986

	Routine Delivery			C-Section	Prenatal			Postpartum			Well Child			Total Obstetrical			Approximate Community Charge	% Covered by OB Fee	Date for Fee Information
	OB-GYN	FP	CNM	OB-GYN	OB-GYN	FP	CNM	OB-GYN	FP	CNM	PED	FP	CNM	OB-GYN	FP	CNM			
AL	$337.50	$337.50	$187.50	$540.00	$11.25	$11.25	$7.00	$27.00	$27.00	$20.00				$450.00	$450.00	$450.00	$1,400.00	32.1%	1986
AK	700.00	700.00	560.00	1,300.00													3,500.00		1986
AZ														575.00	575.00	375.00	1,000.00	57.5	1986
AR	345.00	345.00	225.00	603.00	20.70	20.70		20.70	20.70		20.70	20.70							
CA	328.64	328.64	328.64	821.60				36.52	36.52	36.52	22.08	22.08	8.00	657.28	657.28	657.28	1,500.00	43.8	1986
CO	233.00	233.00	233.00	422.24	14.56	14.56	14.56	29.12	29.12	29.12	33.45	33.45	33.45	510.00	510.00	510.00	1,200.00	42.5	1986
CT	609.70	609.70	609.70	812.50	26.00	26.00	26.00	26.00	26.00	26.00	18.70	18.70	18.70	861.30	861.30	861.30	1,750.00	49.2	1986
DE	321.78	321.78	321.78	475.75	11.10	11.10	11.10	15.00	15.00	15.00	21.20	21.20							7/87
DC*																			
FL	232.00	232.00	185.60	368.00	10.00	10.00	8.00	20.50	20.50	16.40	25.00	25.00	20.00	315.00	315.00	252.00	1,800.00	17.5	1986
GA*																			
HI	238.50	238.50	178.88	477.00	13.25	11.58		13.25	11.58		14.47	14.47		416.54	326.39	312.41	837.00	49.8	1987
ID*																	1,125.00		
IL	304.30	304.30	304.30	460.85	12.65	12.65	12.65				20.15	20.15	20.15	446.50	446.50	446.50	1,850.00	24.1	1986
IN*																			
IA	505.00	411.78		675.00	26.00	23.50		15.24	13.06		46.65	46.65		549.04	446.09		1,000.00	54.9	1986
KS	338.30	338.30		457.80	12.00	12.00		18.00	18.00		35.00	35.00		459.40	459.40				1986
KY	250.00	250.00	188.00	300.00	20.00	20.00	15.00	20.00	20.00	15.00	20.00	20.00	15.00				1,300.00	36.2	10/86
LA	302.96	302.96	302.96	611.68	20.09	20.09	20.09	38.44	38.44	38.44	17.00	17.00	17.00				1,000.00	62.3	1986
ME	266.00	266.00	239.00	266.00	19.50	19.50	17.50	19.50	19.50	17.50	26.00	26.00		500.00	500.00	450.00	1,000.00	50.0	1986
MD	795.00	795.00	795.00	848.00	21.00	21.00	21.00	21.00	21.00	21.00	21.00	21.00					2,400.00	42.8	1986
MA														1,508.00			3,500.00	43.1	
MI	375.21	375.21	375.21	569.28	25.74	25.74	25.74	15.86	15.86	15.86	16.20	16.20	16.20				1,675.00	38.7	1986
MN																	2,250.00		
MS																	1,150.00		
MO	220.00	220.00	220.00	369.00	17.00	17.00	17.00				28.00	28.00	28.00	425.00	425.00	425.00	1,350.00	31.5	1986
MT	384.00	384.00	384.00	464.28	17.50	17.50	17.50	25.00	25.00	25.00				619.00	619.00	619.00	911.00	67.9	1987
NE	457.80	350.00		629.20	20.00	20.00		20.00	20.00		35.00	35.00		597.70	440.40		785.00	76.1	1986
NV	534.00	534.00	368.00	917.00	17.00	17.00	12.00	17.00	17.00	12.00	70.00	70.00		708.00	708.00	488.00	950.00	74.5	1986
NH	150.00	150.00	150.00	275.00	10.00	10.00	10.00	10.00	10.00	10.00		8.00	8.00	214.00	214.00	214.00	1,000.00	21.4	1986
NJ	160.00	144.00	112.00	290.00	8.00	8.00		8.00	7.00		9.00	7.00		236.00	210.00	165.20	1,600.00	14.8	1986
NM	294.34	294.34		510.46	18.33	18.33		18.33	18.33					502.03	502.03		1,000.00	50.2	1986
NY	350.00	350.00		359.00	17.00	17.00	7.00	17.00	17.00					550.00	550.00	200.00			1986
NC	350.00	350.00	350.00	580.00	21.00	21.00	21.00	21.00	21.00	21.00	21.00	21.00	21.00	625.00	625.00	625.00	1,200.00	52.1	10/87
ND*																			
OH	350.00	350.00	350.00	400.00	20.00	20.00	20.00	22.00	22.00	22.00	35.00	35.00	35.00				1,050.00	54.5	1986
OK	525.00	525.00	525.00	650.00	33.00	33.00	33.00	40.00	40.00	40.00	33.00	33.00	33.00	725.00	725.00	725.00			1986
OR	286.13	286.13	229.00	536.79	17.89	17.89	14.30	89.70	89.70	71.76	24.39			501.93	501.93	401.54	1,100.00	45.6	1986
PA	312.50	312.50	312.50	459.00	13.00	13.00	11.00	13.00	13.00	11.00	13.00						2,250.00	20.2	1986
RI	750.00	750.00	750.00	750.00	18.00	18.00	18.00	18.00	18.00	18.00	20.00	20.00	20.00				1,400.00	67.7	4/87
SC	275.00	275.00	249.00	418.00	15.00	15.00	15.00	17.00	17.00	17.00	33.00	33.00		485.00	485.00	375.00	1,000.00	48.5	1986
SD	186.00	186.00	186.00	445.00	12.00	12.00	12.00	15.00	15.00	15.00				325.00	325.00	325.00	675.00	48.1	1986
TN	362.50	325.00		650.00	30.00	30.00		50.00	50.00		14.00	14.00		725.00	650.00		1,250.00	58.0	5/86
TX	434.36	434.36		689.15	14.40	14.40		14.40	14.40		30.05	30.95		442.10	442.10		1,800.00	24.6	1986
UT	325.00	325.00	265.00	387.00	44.00	44.00	44.00	33.00	33.00	33.00				519.00	519.00	448.00	1,700.00	30.5	1986
VT	170.00	170.00	153.00	320.00	15.00	15.00	13.50	15.00	15.00	13.50	17.00	17.00		350.00	350.00	315.00	1,150.00	30.4	1986
VA	450.00	450.00	450.00	645.00	15.80	15.80	15.80	17.00	17.00	17.00	15.75	15.75	15.75	625.00	625.00	625.00	1,900.00	32.9	7/86
WA	330.24	330.24	232.69	440.35	55.04	55.04	42.66	35.03	35.03	27.15	27.58	27.58	27.58	600.48	600.48	465.37	1,200.00	50.0	1986
WV																	1,200.00		
WI	357.57	357.57	286.06	474.79	16.23	16.23	12.98	16.23	16.23	12.98	18.39	18.39		590.22	590.22	472.18			1986
WY	276.75	276.75		590.40	20.00	20.00		20.00	20.00		20.00	20.00		553.50	553.50		1,200.00	46.1	1986

NOTE: *Information not available.

SOURCE: National Governors' Association Survey of Provider Participation, 1988.

but in a few the difference was dramatic (over $1,000). In these cases, the reported data was compared with that from neighboring states and a judgment made on the more likely figure.

7. In calculating the percent of approximate community charge covered by the Medicaid program, the following methodology was used.
   - Where the Medicaid program uses "total obstetrical payment," the reported reimbursement rate for OB-GYNs was used.
   - Where the Medicaid program does not have global billing, an equivalent payment was calculated, based on the reimbursement rates to OB-GYNs. This calculation included (1) the fee for routine delivery, (2) one postpartum visit, and (3) ten prenatal visits. If the state reported a total prenatal care package rate, that was used for the prenatal care component of the calculation.

Appendix 3

Analysis of Responses in the Preliminary and Final Reports

The discussion draft prepared in January 1988 for the NGA Workshop on Provider Participation included analysis of responses received from 62 agencies–33 Maternal and Child Health and 28 Medicaid. The number responding to particular questions ranged from 55 to 62 agencies (30-33 MCH and 24-28 Medicaid).

The final report includes data from 80 agencies representing 50 states. A response was received from at least one agency in all surveyed jurisdictions except the District of Columbia. Final responses include 37 Maternal and Child Health agencies and 43 Medicaid agencies. For particular questions, the number responding varies from 32 to 38 among MCH and 37 to 43 for Medicaid.

The direction of the survey findings did not change between the preliminary and final reports. However, because of the major increase in the number of responding Medicaid agencies, some of the percentage distributions changed significantly. Preliminary and final responses for each of the eight tables included in the preliminary report are shown in this section. (See Tables 18-25.) The primary differences are as follows:

- Agencies reporting that malpractice reforms have not improved provider participation increased from 70.7 percent to 75.7 percent.
- Agencies reporting that they believe low fees are the primary deterrent to physician participation declined from 50.9 percent to 45.9 percent. The change is particularly noticeable among Medicaid agencies. In the final report 53 percent of Medicaid agencies rank low fees first, compared with 67 percent in the preliminary report. Conversely, 21 percent ranked fees "number 2," compared to 12.5 percent in the preliminary data. The proportion of Medicaid agencies reporting that complex forms were the most important factor doubled.
- Data on reasons given by physicians for not participating show a similar, but less pronounced shift. Among Medicaid agencies, the proportion ranking fees first dropped from 62.5 percent to 55.3 percent. The proportion of MCH agencies ranking this factor first remained unchanged, but the proportion ranking it second dropped from 40 percent to 35 percent.
- Data on changes in obstetrical practice changed slightly. The proportion of agencies reporting that OB-GYNs were dropping obstetrics increased, primarily due to the larger number of Medicaid respondents citing this problem. The proportion reporting that physicians

were reducing participation in public programs dropped--among Medicaid agencies from 60 percent to 55 percent reporting this problem.

- A higher proportion of Medicaid agencies reported that risk status of low-income patients is a major reason physicians give for not participating in public programs.
- The proportion of agencies reporting implementation of initiatives to use alternative providers and improved coordination among agencies increased with the change principally occurring among the Medicaid programs.

Table 18
Agencies Reporting Significant Participation Problems

	Maternal and Child Health		*Medicaid*		*All Agencies*	
	Preliminary	*Final*	*Preliminary*	*Final*	*Preliminary*	*Final*
Yes	87.9%	89.2%	64.3%	62.8%	77.4%	75.0%
No	12.1	10.8	28.6	30.2	19.4	21.3
Unsure	0.0	0.0	7.1	7.0	3.2	3.8
Agencies Responding	33	37	28	43	62	80

SOURCE: National Governors' Association Survey of Provider Participation, 1988.

Table 19
Agency Views on Whether Rising Malpractice Costs have Affected Provider Participation

	Maternal and Child Health		*Medicaid*		*All Agencies*	
	Preliminary	*Final*	*Preliminary*	*Final*	*Preliminary*	*Final*
Yes	100.0%	100.0%	82.1%	86.0%	91.9%	92.5%
No	0.0	0.0	17.9	14.0	8.1	7.5
Agencies Responding	33	37	28	43	62	80

SOURCE: National Governors' Association Survey of Provider Participation, 1988.

Table 20
Agency Views on Whether Malpractice Reforms have Helped to Improve Provider Participation

	Maternal and Child Health		*Medicaid*		*All Agencies*	
	Preliminary	*Final*	*Preliminary*	*Final*	*Preliminary*	*Final*
Yes	12.1%	10.8%	4.2%	5.4%	8.6%	8.1%
No	57.6	62.2	87.5	89.2	70.7	75.7
Unsure	9.1	8.1	4.2	2.7	6.9	5.4
No reforms	21.2	18.9	4.2	2.7	13.8	10.8
Agencies Responding	33	37	24	37	58	74

SOURCE: National Governors' Association Survey of Provider Participation, 1988.

Table 21
Percentage of Agencies Reporting Selected Changes in Availability of Obstetrical Care

	Maternal and Child Health		*Medicaid*		*All Agencies*	
	Preliminary	*Final*	*Preliminary*	*Final*	*Preliminary*	*Final*
Providers Dropping OB						
OB-GYNs	96.9%	97.2%	80.0%	89.5%	89.7%	93.2%
GP/FP	87.5	88.9	84.2	84.2	84.5	86.5
CHCs	6.3	11.1	12.0	7.9	8.6	9.5
OB-GYNs not taking new patients	81.3	80.6	88.0	86.8	84.5	83.8
Physicians reducing participation	84.4	83.3	60.0	55.3	74.1	68.9
OB-GYNs reducing high-risk care	81.3	80.6	52.0	55.3	69.0	67.6
Physicians withdrawing from public programs	75.0	77.8	48.0	44.7	63.8	60.8
Hospitals reducing emergency delivery	12.5	11.1	16.0	13.2	15.5	12.2
Total agencies	32	36	25	38	58	74

SOURCE: National Governors' Association Survey of Provider Participation, 1988.

Table 22
Malpractice-Related Reasons Often Given by Physicians for not Participating in Public Programs
(Percentage of agencies reporting reason is "given often")

	Maternal and Child Health		*Medicaid*		*All Agencies*	
	Preliminary	*Final*	*Preliminary*	*Final*	*Preliminary*	*Final*
Fees do not cover premium costs	84.4%	83.3%	87.5%	83.8%	86.0%	83.6%
Poor patients are high-risk	62.5	63.9	41.7	48.6	54.4	56.2
Poor patients sue more	43.8	44.4	25.0	24.3	36.8	34.2
Poor patients do not get prenatal care and are high-risk	25.0	22.2	33.3	40.5	28.1	31.5
Cannot deliver patients not seen before	21.9	22.2	16.7	13.5	19.3	17.8
Cannot afford to give charity care	12.5	11.1	12.5	16.2	14.0	13.7
Total Agencies	32	36	24	37	57	73

SOURCE: National Governors' Association Survey of Provider Participation, 1988.

Table 23
Agency Initiatives to Promote Participation Implemented Since 1985 (Includes only initiatives reported by at least 20% of respondents)

	Maternal and Child Health		*Medicaid*		*All Agencies*	
	Preliminary	*Final*	*Preliminary*	*Final*	*Preliminary*	*Final*
Raise fees	63.6%	64.9%	76.0%	74.4%	67.8%	69.7%
Expand eligibility	48.5	51.4	62.5	57.9	53.4	54.7
Case management	42.4	45.9	33.3	31.6	37.9	38.7
Use alternative providers	24.2	24.3	32.0	41.0	27.1	32.9
Improve coordination among agencies	30.3	32.4	20.8	28.9	25.9	30.7
Increase outreach to providers	24.2	27.0	29.2	28.9	25.9	28.0
New methods of payment	18.2	21.6	29.2	31.6	22.4	26.7
Voluntary efforts with medical society	24.2	24.3	20.8	18.4	22.4	21.3
Simplify bills	6.1	10.8	25.0	21.1	13.8	16.0
Provide malpractice insurance for MDs under contract	24.2	21.6	0.0	0.0	15.5	10.7
Agencies responding	33	37	25	38	59	75

SOURCE: National Governors' Association Survey of Provider Participation, 1988.

Table 24
State Agency Views of the Principal Reasons Given by Physicians for Nonparticipation

	Percent Giving Highest Rank		*Percent Giving Rank #2*	
Reasons for Nonparticipation	*Preliminary*	*Final*	*Preliminary*	*Final*
Low Fees				
MCH	36.7%	38.2%	40.0%	35.3%
Medicaid	62.5	55.3	16.7	15.8
Total	47.3	47.2	30.9	25.0
Malpractice				
MCH	40.0	41.2	30.0	29.4
Medicaid	20.8	18.4	29.2	31.6
Total	32.7	29.2	29.1	30.6
Complex Forms				
MCH	0.0	0.0	6.7	11.8
Medicaid	12.5	13.2	25.0	23.7
Total	5.5	6.9	14.5	18.1
Client Problems				
MCH	3.3	2.9	10.0	8.8
Medicaid	0.0	2.6	8.3	5.3
Total	1.8	2.8	9.1	6.9
View of Program				
MCH	0.0	0.0	3.3	2.8
Medicaid	0.0	0.0	0.0	0.0
Total	0.0	0.0	1.8	1.4
Payment Delay				
MCH	0.0	0.0	3.3	5.9
Medicaid	0.0	0.0	12.5	13.2
Total	0.0%	0.0%	7.3%	9.7%

Total Responses
Preliminary - 55 for total; 30 for MCH; 24 for Medicaid
Final - 72 total; 34 MCH; 38 Medicaid

SOURCE: National Governors' Association Survey of Provider Participation, 1988.

Table 25
State Agency Views of the Principal Reasons for Low Provider Participation

	Percent Giving Highest Rank		*Percent Giving Rank #2*	
Reasons for Nonparticipation	*Preliminary*	*Final*	*Preliminary*	*Final*
Low Fees				
MCH	40.6%	38.9%	34.4%	30.6%
Medicaid	66.7	52.6	12.5	21.1
Total	50.9	45.9	26.3	25.7
Malpractice				
MCH	21.9	25.0	34.4	30.6
Medicaid	16.7	18.4	37.5	31.6
Total	21.1	21.6	35.1	31.1
Complex Forms				
MCH	0.0	2.8	9.4	8.3
Medicaid	8.3	15.8	16.7	10.5
Total	3.5	9.5	12.3	9.5
Client Problems				
MCH	9.4	8.3	18.8	22.2
Medicaid	4.2	5.3	0.0	7.9
Total	7.0	6.8	10.5	14.9
View of Program				
MCH	9.4	8.3	6.3	8.3
Medicaid	0.0	0.0	4.2	3.6
Total	5.3	5.4	5.3	4.1
Payment Delay				
MCH	3.1	2.8	9.4	11.1
Medicaid	0.0	0.0	16.7	13.2
Total	1.8%	1.4%	12.3%	11.2%

Agencies Responding
Preliminary - 57 for total; 32 for MCH; 24 for Medicaid
Final - 74 total; 36 MCH; 38 Medicaid

SOURCE: National Governors' Association Survey of Provider Participation, 1988.

Endnotes

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22. This paragraph summarizes the general trends from the literature. Individual studies may differ. For example, Hadley found a small negative but significant relationship between participation and foreign medical graduates while Perloff et al. found positive relationships.

23. See Mitchell, "Medicaid Participation Among Medical and Surgical Specialists" and Mitchell and Schurman, "Access to Private Obstetrics/Gynecology Services Under Medicaid."

24. Mitchell and Schurman, p. 1034.

25. Mitchell and Cromwell.

26. Data from the American Medical Association, Socioeconomic Monitoring System Surveys, tabulated in the Department of Health and Human Services, *Report of the Task Force on Medical Liability and Malpractice* (August 1987), p. 170.

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Reaching Women Who Need Prenatal Care: Strategies for Improving State Perinatal Programs by Ian T. Hill. June 1988. $15.00.

Since early 1987, a majority of states have implemented expanded Medicaid programs for pregnant women and young children living in poverty. In order to improve these populations' access to early and appropriate prenatal care, this book describes how numerous states are also reshaping and enhancing their systems for eligibility and outreach. Extensive discussion of presumptive eligibility is included.

Estimating Medicaid Eligible Pregnant Women and Children Living Below 185 Percent of Poverty: Strategies for Improving State Perinatal Programs by Paul W. Newacheck. June 1988. $15.00.

A companion document to the previous year's report, this volume projects, by state, potential eligibles under OBRA-87 in families with income below 185 percent of poverty.

Estimating the Number and Costs of Newly Medicaid Eligible Pregnant Women and Infants: A Technical Report on Implementing the 1986 Omnibus Budget Reconciliation Act by Paul W. Newacheck and Margaret A. McManus. March 1987. $15.00.

This report is designed to assist states in estimating the potentially eligible populations of pregnant women and children under expanded, poverty-level Medicaid programs. Individual state estimates are provided.

Implementing a Workable Presumptive Eligibility Program: The Experience In Arkansas by Ian T. Hill. June 1987. $5.00.

The country's first presumptive eligibility program (to allow pregnant women to receive short-term Medicaid coverage while formal eligibility is being determined) is highlighted in this case study. Early problems, issues, and strategies surrounding implementation are described in detail.

Broadening Medicaid Coverage of Pregnant Women and Children: State Policy Responses by Ian T. Hill. February 1987. $9.00.

This volume describes, in detail, the provisions of the Omnibus Budget Reconciliation Act of 1986, which allowed states to expand Medicaid coverage of pregnant women and children up to the poverty level. Early projections are made regarding expected state responses. Additionally, baseline data regarding states' existing coverage of maternal and child populations prior to OBRA-86 are provided.

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